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CANADA
MEDICAL RECORD

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# Original Communications.

## PYOPERICARDIUM FOLLOWING PLEURO-PNEUMONIA—PERICARDIOTOMY—RECOVERY.

By J. BRADFORD McCONNELL, M.D. (1)

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine, University of Bishop's College, Montreal.

The fact that but a few cases of purulent pericarditis, with its treatment by pericardiotomy are on record seems sufficient justification for placing the details of this case before you.

The following history of the case is condensed from the detailed daily record: The patient, Charles D., occupation; jeweler, aged 33 years, was first seen on April 12, 1897. The previous day he had been seized with chills and a severe pain at the lower part of the left thorax in front, which radiated towards the umbilicus. It continued to increase in severity, and was accompanied by cough and fever. Two months previous to this time he had suffered from an attack of La Grippe, from which he had fairly well recovered, except the cough, which continued off and on up to the time of the present attack. At the first examination the pain appeared to be in the region of the diaphragm on the left side, and diaphragmatic pleurisy was suspected. The pain was increased by coughing and by deep breathing. Pain was also complained of in the infraclavicular region, on front. Pulse was 120; respiration, 24; temperature, 103° F.

(1) Read at the Montreal Medico-Chirurgical Society, Oct. 15, 1897.

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There was also headache. Other than diminished respiratory sounds, no abnormal physical signs could be made out; powders containing caffeine, acetanilide and codein failed to relieve the pain, and a hypodermatic injection of morphine and atropine was required. On the 14th the pain had not diminished. Respiration, 28; pulse, 104; temperature, 104° F. There was dullness on percussion over the upper lobe of the left lung, diminished fremitus at the base behind and a grazing pleuritic friction sound. Cough not severe, well marked rusty viscid sputum. Ice-water compresses were applied, and internally liq am. acet. fl. ext. ergot, acidi boric, Tr. Camph. Co., Syr. Limon and aq. Camph. Morphine and atropine, hypodermically, had to be given daily. On the 15th tubular breathing was present in the upper lobe in front. On 17th this condition was much the same, with dullness on percussion at the left base behind, and increased vocal fremitus throughout the left lung. On the 20th symptoms had all abated and lung was clearing. There were rales at the base before and behind.

On the 21st he complained of a pain at the left margin of sternum, respiration, 48; pulse, 112; temperature, 100 3-5°. A pericardial friction murmur can be heard over the heart; heart sounds distinct, clear and normal. On the 23rd no friction murmur could be made out. Pulse, 116; respiration, 44; temperature, 98°. Each alternate systole gave a peculiar accentuated flapping sound. This disappeared on the following day, rhythm normal. Coarse rales are heard more or less generally over left lung.

On the 24th and 25th pain was complained of at right base in front, and a pleuritic friction sound was well marked there. Sinapisms were applied, and he required almost daily hypodermatic injection of morphine, atropine and digitalin. He had occasional vomiting attacks.

The general condition remained the same until the end of the month. There was now evidence of an extensive accumulation in the pericardium. Temperature remained normal, pulse averaging 120 and respiration 36. From the 1st of May to the 10th the effusion gradually increased; he now had difficulty in swallowing; the act caused him

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severe pain at the cardiac end of the stomach and lower end of œsophagus. The pulmonary condition had now cleared up—there was but little cough—and there is no marked dyspnœa and no chills nor febrile attacks nor sweating.

The physical signs on the 12th were as follows: Decubitus on back and left side. Cannot lie on right side. There was diminished movement on the left side and below the fourth rib, the interspaces were widened and pressed to a level with the surface of the ribs. No heart impulse is visible. The epigastrium is somewhat prominent. Palpation does not give evidence of any impulse of the heart; the interspaces from the 2nd to the 6th are tense. The upper margin of the first rib could be felt to its sternal attachment, a symptom of these cases pointed out by Ewart. No fremitus could be made out on the lower two-thirds of the front or side of the left chest, it was diminished behind, but increased at the apex on front and behind. Percussion shows extensive dullness radiating from the cardiac region. At the 4th rib it extends from 1¾ inches to the right of the sternum to 1 inch to the left of the left nipple. The line of dullness then slanting down to the fourth intercostal space in the axilla. It extends from the upper margin of the 2nd costal cartilage to the liver, which is depressed about 2 inches. Three days before the date of this examination a square patch of dullness existed to the left of the spines of the vertebræ from the 9th to the 12th, described by Ewart as the posterior patch of pericardial dullness, but it had now increased and extended into the axilla, and up as high as the angle of the scapula. There was probably some pleuritic effusion as well, as the dullness extended down to the 10th rib in the axilla. The sternum was absolutely dull as was also the fifth right intercartilaginous space, the line of dullness curving outwards to that of the liver, the cardio-hepatic triangular area of resonance being quite obliterated. By placing the rod of the phonendoscope over the heart and rubbing with the finger, vibrations were perceived which enabled the heart to be outlined in its normal position, and of normal size, thus differentiating it from the dullness of the surrounding effusion. The liver dullness could also in the

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same way be distinguished from that of the pus accumulation. Traube's semi-lunar space was quite obliterated. Stethoscopic auscultation revealed the heart sounds very indistinct and muffled, the 2nd pulmonic sound was accentuated. No respiratory sounds at left base in front up to fourth space nor below the axilla, feeble behind, tubular at the angle of the scapula and along the edges of the vertebræ down to the 8th. No tubular breathing could be made out below the right mamma, exaggerated respiration at the apex. A creaking sound is heard in the left infra axillary region, most distinct during expiration. The patient could not swallow solids, and liquids caused pain, and they were sometimes regurgitated through the nose. No rales, and the patient has no cough. On the 13th pulse, 144; respiration, 40; temperature, 101°; a hypodermic injection of morphine, atropine and digitalin was given in the evening. On the 14th a.m. paracentesis pericardii was performed; no anæsthetic was given. Before the operation, P. 132, R. 28, T. 97 4-5°. I was assisted by Drs. F. G. Finley and H. S. Shaw. The trocar entered in the 5th left interspace 1¾ inches from the sternum. Sixty ounces of creamy pus was removed. He experienced marked relief. The pulse remained regular and of good volume, and after the operation had slowed down to 92, R. 32. The pus was submitted for examination to Dr. MacPhail, who reported that the diplococcus of Fraenkel was found in pure culture, reacting to all the usual tests for this micro-organism. No other species was found.

The following day he developed a mild conjunctivitis, and later a small ulcer appeared at the lower part of the right cornea, which healed within a week. The heart sounds were now quite distinct and regular, no abnormal signs present. A pain in the cardiac region in the evening required a hypodermatic injection; and this was required almost daily, giving rest and improving markedly his general condition.

On the 18th the heart sounds were less distinct. A cardiac dullness extended from right edge of sternum to ½ inch to left of left nipple, and from 2nd space to liver on right, and joined the pleuritic dullness on the left. The pulse

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and respiration became more rapid up to the 22nd, when the cardiac dullness equalled what it was at the time of aspiration eight days previously. No heart sounds could be heard, and the cardiac dullness did not extend over two inches to the right of the sternum. On the 22nd May, assisted again by Drs. Finley and Shaw, pericardiotomy was performed. Morphine ¼, atropine 1-150 and digitalin 1-100 were given half an hour before; a mixture of chloroform, 2 parts, and ether 1 part was used. It was given cautiously by Dr. Finley, and not pushed to deep anæsthesia. The interspaces were wide; but it was not thought necessary to excise any of the ribs. An incision an inch long was made in the fifth interspace, its outer end extending to about 2 inches from the left edge of the sternum; the intercostal muscles retracted from the incision, leaving a free opening, through which could be seen the distended pericardium. It felt hard, and was pulsating, giving the impression of being a dilated auricle or ventricle, a small exploratory trochar gently pressed through allowed a few drops of a thick pus to appear. The pericardium was then seized with a mouse-tooth forceps and incised; when pus welled out freely, in it were several large fibrinous flocculi. The quantity measured 66 ounces. The air would rush in and out with each act of the heart's beat; the pericardium was about ¾ of an inch from the ribs. The opening was now behind the fifth rib, and the pericardium required to be seized with forceps and pulled down to put in the drainage tube. For this purpose, a portion of a soft rubber catheter, No. 12, was used. The rounded extremity readily entered the cavity. It was retained with a safety pin and rubber adhesive plaster, and packed around and covered with sublimated gauze, and, over this, jute. The sternum and all the left side of the chest, except the lowest part in the axillary line, was now hyper-resonant. The heart sounds were distinct, and the pulse had remained regular.

At the first dressing, next day, it was found that a large quantity of purulent fluid had escaped, passing through the thick dressings, clothing and sheet into the mattress. On the 24th, the respiration was 36, P. 130, T. 100-4-5°; but there was no pain nor cough, nor distress, and he was taking nourishment freely. The temperature was normal the next

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day, and remained so. The wound was cleansed daily with hydro-naphthol solution ; none entered the cavity of the pericardium ; but the space between the pericardium and chest wall required washing out, and at each dressing, airol was freely dusted in. The drainage tube entered about 2 inches into the pericardial sac. After removing the dressings, a continuous puffing in and out of air through the chest opening occurred, caused by the heart's movement, which could be readily seen. The discharge gradually ceased, and by the 1st June had almost entirely stopped. The tube was shortened from time to time, the cavity gradually closing after it. There was a keen tendency for the outer wound to heal, which required firm packing with the sublimated gauze to prevent it. The phonendoscope on the left side revealed one preponderating sound only, the puffing through the opening in the chest. There is dullness in the infra-axillary and infra-scapular regions; respiratory sounds very indistinct in the same region.

On the 11th of June the tube was removed, and a small piece of sublimated gauze placed in the outer wound daily, to allow the cavity beneath to fill out before the intercostal opening closed. By the end of the month the parts had entirely healed, and, on July the 3rd, all dressings were finally removed. P. 132, R. 24, T. 98 2-5°. Heart sounds now clear, but distant in character. The patient has been taking, since the operation, Iron Quinine and Stychnine, and has steadily improved and gained in weight, and presents a marked contrast to the emaciated condition which obtained at the time of operation. He has been walking about the room for about a week ; the ankles are very much swollen each evening ; this gradually disappears during the night. In about three weeks this ceased entirely.

Although not bearing on the case, it may be noted that the patient passed through a subsequent attack of pneumonia from July 30th ro August 7th, 1897, the consolidation occupying the lower and middle lobe of right lung.

At the present time (Oct. 15th, 1897)—as you may ascertain by examining the patient—he is in a fairly normal condition, and weighs more than before he became ill. There is an appreciable dyspnœa on exertion, and when talking

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continuously. Chest measurement is equal on either side (15½ inches). There is no visible impulse, nor can the heart's beat be felt on palpation, unless the tip of the finger is pressed into the cicatrix of the incision wound. There is moderate hypertrophy, but none of the usual signs of adherent pericardium other than a slightly marked diastolic shock. The heart's sounds are normal, but somewhat frequent, averaging 85 beats per minute. Vocal fremitus is diminished in the lower half of left chest, as also are the respiratory sounds.

The number of recorded cases of suppurative pericarditis appears to be very limited, and especially so the number of cases in which the treatment by incision and drainage has been adopted.

A case was recently reported by Bohn (*Deutsch Med. Wochenschr*, Nov. 26, 1896) somewhat similar to the present one. It followed La Grippe and pleuro pneumonia. The pericardial sac was opened one month after the beginning of the disease, and over a litre of pus removed. He was unable to introduce a drainage tube, and had to drain with gauze. The sac was washed out with a solution of boracic acid. The opening in the pericardium closed in three weeks. Three months after the pericardiotomy the heart and lungs were in nearly a normal condition. He speaks of his as the fifteenth case on record. Eight of these recovered. Of the seven deaths one resulted from the irritation of the irrigating fluid; one from the degenerations of heart muscle; one had aural abrasions; the other from such complications as pneumonia, empyema and nephritis.

In the journal of the *American Medical Association*, June 26, 1897, Dr. Frank W. Garber, of Muskegon, Mich., reports a case of traumatic origin. Only about an ounce of pus was removed, the patient recovering. A *résumé* of the literature on the subject is given by him. It was in 1819 that pericardiotomy was first performed. He says Romero, of Barcelona, operated on two cases. Two recovered. In an article by Delorme and Mignon, *Revue de Chirurgie*, October, 1896, a *résumé* of which appears in the Montreal *Medical Journal*, April, 1896, it is stated that puncture of the pericardium was first proposed by Riolan in 1646.

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In 1840 Schier performed paracentesis in pericarditis due to cancer. The patient lived for six months after. The first case of tapping the pericardium in the United States was in 1852 by Dr. Warren, of Boston, and the first authentic case of incision and drainage in purulent pericarditis is reported in the *Berliner Klin. Wochenschrift*, 1881, 5th No. The patient was a boy, ten years of age, by paracentesis several ounces of pus were removed; later, incision and drainage led to recovery.

The operation of pericardiotomy was first performed in England by Dr. Samuel West in 1883. The case recovered. He refers to 79 cases with 36 recoveries. In 1885 Michaeloff operated, the patient dying a short time after the operation.

Gussenbauer, in the same year, had a successful case; after incision, drainage and irrigation, the ribs were revealed.

Davidson reports two cases in the *British Medical Journal*, March, 1891; two boys aged seven and six were treated this way, one recovering.

Beckman and Stall report a successful case; Bronner, one which terminated fatally. Scott, in the New Zealand *Medical Journal*, July, 1891, reports a successful case where irrigation with 15 to 1,000 carbolic was part of the treatment.

Edwards, in the International Medical Magazine, June, 1896, operated on a child six years of age, purulent pleuritic effusion and death followed.

Eiselberg, of Utrecht, reports a case of traumatic purulent pericarditis. Three tappings failed to give permanent relief. They occurred at intervals of a few days, and one litre was removed each time. The fourth costal cartilage was removed a few days after, and two litres of sero-purulent fluid containing fibrinous clots were noted. He irrigated the borders of the pericardium, which were stitched to the outer wound, to prevent infection of pleura. He injected iodoform and glycerine emulsion daily. Tube was removed in 17 days, and, 4 weeks after, the wound had completely cicatrized.

William Pepper, J. H. Mussen and John B. Deaver, of Philadelphia, in the *University Medical Magazine* for Feb., 1894, mention a case in a man, following influenza, where, paracentesis and the incision and drainage were performed.

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Improvement was temporary only. The patient died two weeks after the operation.

Wilson, of Nashville, Tennessee, operated on one case of serous effusion in the right fifth intercostal space.

R. Siewers, of Finland, in 1894 reported nine cases; four successful.

*Medical Press* and *Circular*, January 27th, 1893, Koerte mentions the removal of a litre of pus from the pericardium from a girl of seven years; the patient died.

Ferier, in 1890, had collected 22 cases with 20 deaths, in 16 of purulent effusion, 11 aspirated died; the remaining 5 were incised, 3 recovering.

Musser, in his work on medical diagnosis, reports a case of tuberculous pericarditis, were 64 ounces of fluid was found in the pericardium at the autopsy; he had previously been tapped.

The most recent case was one by Drs. Shattuck and C. B. Porter (Boston *Medical and Surgical Journal*, May 6th, 1897) in a man 26 years of age. Purulent pericarditis followed pneumonia, aspiration was followed by rapid reaccumulation, incision and drainage led to complete recovery.

From this brief *résumé* of the literature, it will be seen that it is not very extensive, and one cannot very readily separate the cases of simple serous effusion where the treatment was by paracentesis or incision, from those of purulent pericarditis. If Bohm's statistics are correct, then the case will be the nineteenth on record where pericardiotomy has been resorted to in purulent pericarditis, with seven recoveries.

The points of interest in this case are first, the causation by contiguity of an active pneumococcis growth in the lung, with the comparative absence of symptoms of sepsis; not only did the heart accommodate itself to this large accumulation but gave slight evidence of distress, and there was but little constitutional disturbance in the way of fever; the derangements resulting were apparently only mechanical.

The quantity is the largest for an accumulation of pus yet recorded; larger amounts of serous and seropurulent collections have been described.

Louis, in 36 cases, found 9 serous, 5 sero-sanguinolent

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13 sero-purulent, 7 purulent, reports the quantities removed as ranging from 200 to 1,000 gms. and in one case 1,500. The rapidity of the re-accumulation of the pus is also noteworthy. An important point in diagnosis is illustrated in this case, which I have not yet seen mentioned; it is the advantage afforded by the phonendoscope in helping to distinguish pericardial effusion from dilatation and from pleural accumulations. In this case, and doubtless in all where the effusion does not force the heart too far from the chest (if it ever does so), one could with the phonendoscope readily make out the heart in the midst of the effusion, while the latter was outlined by percussion. In a recent case of large left hemorrhagic pleuritic effusion also, out of the uniform flatness of percussion one could clearly locate the heart, which was not pushed to the right, although 86 ounces were removed by aspiration, doubtless owing to the age of the patient and the rigidity of the attachments which retained the heart in its normal position. This is one advantage of the phonendoscope which is worthy of further investigation. I found in this case and in others that the phonendoscope is less to be relied upon than the stethoscope. Misleading sounds resembling crepitus or grazing are produced by the instrument itself when not in perfect contact with the surface, as over the ribs in one emaciated, and in a recent case of double pneumonia, tubular breathing was not revealed by the phonendoscope, although quite distinct with the stethoscope.

It is of surgical interest also in the case, which I believe is the rule, that one can rapidly remove the accumulation without any risk of heart failure symptoms. The avoidance of the internal mammary artery—which descends half an inch from the edge of the sternum—and the pleura are among the chief points for consideration in incision or tapping. The latter is considerably pushed aside by a large accumulation, and normally recedes towards the left from the upper border of the fifth costal cartilage. They are both avoided by selecting a point 1½ to 2 inches to the left of the sternum. The general results have so far been fairly good for incision, and, doubtless if the diagnosis and operation are made earlier, the mortality in these cases will be much less than in the past.

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Delorme and Mignon have collected 102 cases; 61 died; 82 were punctured, with a mortality of 65 per cent., and 18 incisions with 38 per cent. mortality.

A case is recently reported by Menetrier and Reneau, of purulent pericarditis due to the pneumococcus, where pneumonia was not present, and where a primary pericarditis was suspected. The autopsy revealed only bronchitis the primary source, then an enlarged mediastinal gland, from which the pericardium received the infection.

One of the most recent contributions on this subject is the paper by J. B. Roberts, A.M., M.D., Philadelphia, which was read at the meeting of the American Surgical Association, May, 1897, which should be read by all surgeons contemplating this operation (published in the December No., 1897, *American Journal of the Medical Sciences*). The author considers it mostly from the point of view of its surgical treatment. He strongly advocates incision in all cases of pyopericardium, and, even where the effusion is serous, most cases should be treated preferably by incision rather than cardiocentesis.

He says it establishes diagnosis in dubious cases, avoids cardiac injury, saves the pleura from puncture, affords complete evacuation of effusion, permits extraction of thick pus and membranous lymph, and gives opportunity for disinfection of the sac when that is necessary.

In most of the methods of operation hitherto employed there is danger of wounding the pleura by the puncturing needle. Hence, Dr. Roberts advises exploring through the upper part of the left xyphoid fossa, and if pus is found, to incise the pericardium after resecting the 4th and 5th costal cartilage on the left side; a sort of trap door is made and turned upwards utilizing as a hinge the soft tissue in the third intercostal space.

Dr. Roberts gives a classification of thirty-five cases on record of incision of the pericardium, with operator's name and results. The following is a *résumé* of it: Hilsmann, 1844, recovery; Langenbec, 1850, recovery; Rosenstein, 1879, recovery; West, 1882, recovery; Partzevsky, 1882, death; West, 1883, death; Savory, 1883, death; Scott, 1883, recovery; New-

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man, 1885, death; Mikhailov, 1885, death; Gussenbaum, 1885, recovery; Rouse, 1887, recovery; Underhill, 1887, death; Larkin, 1888, death; Halsted, 1890, death; Delorme, 1890, death; Davidson, 1890, death; Davidson, 1890, recovery; Teale, 1890, death; Deacon, 1890, death; Sievers, 1892, death; Korte, 1891, death; Eiselberg, 1894, recovery; Edwards, 1892, death; Jacobson, death; Gabszewiez, 1892, recovery; Robinson, 1893, recovery; Marsh, death; Klefberg, death; Bohm, 1894, recovery; Allen, 1892, death; Stoker, 1892, death; Björkman, 1895, recovery; Porter, 1895, recovery; Garber, 1897, recovery.

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## PROCEDURE IN POST-MORTEM MEDICO-LEGAL EXAMINATIONS.

By CHARLES A. HEBBERT, M. R. C. P., London, F. L. S., Lecturer on Anatomy, etc.

### CASE III.

The next case in this series is that of a fracture of the base of the skull, the result of a blow on the point of the jaw by the fist of an assailant.

This was one of two similar cases occurring within a short period, and has been selected for illustration for the reason that the fracture is not complicated by any other fracture which might have been caused by a fall on the ground—a condition present in my other case.

The injury was the result of an altercation in the street between two working men, the assailant a burly powerful man of six feet in height, and the victim, though muscular, somewhat smaller and weaker. Several blows were exchanged.

The description is as follows:—

The body was that of a young man, 25 years old, of spare muscular power, 5 ft. 6½ in. high, with dark hair and brown moustache. Eyes brown in colour and pupils moderately dilated. Rigor mortis present; hands clenched. The left eye was ecchymosed, and at the external angle there was an irregular lacerated wound ⅝ in. in diameter. There was clotted blood in both ears. On the left cheek, opposite the angle of the mouth, there were two abrasions 1 in. and ¼ in.

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respectively in diameter (caused probably by contact with the ground on falling).

HEAD.—The dura mater at the vertex was apparently normal, the sinuses containing some black fluid and clotted blood.

On removing the brain an hæmorrhage about the size of a half crown was noticed over the 2nd left frontal convolution, and some smaller superficial hæmorrhages over the crura cerebri and pons varolii. The substance of the brain was superficially injured, but beyond that the substance was apparently healthy. The lateral ventricles contained some blood-stained serum.

On examination of the base of the skull, two linear fractures were discovered, one in each middle fossa, running diagonally from the centre of the anterior surface of the petrous bone to the body of the sphenoid. Each cavernous sinus was opened, and blood had also escaped into the internal ear and external auditory meatus on either side. The glenoid fossa is immediately below the centre of the fracture, which ran backwards through the pétrous bone and forwards through the great wing of the sphenoid. There was also fracture of the basilar portion of the sphenoid.

HEART.—There was old pericarditis and some thickening of the mitral valve. The walls flaccid, and the cavities contained some black fluid blood.

THE LUNGS.—The larnyx and trachea and bronchi showed some softening and swelling of the mucous membrane, and the lungs were markedly congested and odematous; otherwise normal.

THE STOMACH contained about one pint of black coagulated blood. This had evidently drained into the pharynx through the basilar portion of the sphenoid from the cavernous sinus and pterygoid plexuses, and had been swallowed. The other organs were somewhat congested, but the substance was in each case apparently normal. All the organs gave the characteristic odour of alcohol.

The case ended fatally about 12 hours after admission to the hospital, the man never completely recovering consciousness.

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The principal point of interest in this case was that it illustrated the injury suffered by the knock-out blow on the point of the jaw, the blow most devoutly to be desired by the pugilist either for infliction on his opponent or avoidance by himself. The injury is two-fold ; it may, as in this case and in another under my observation, be fracture of the base of the skull, and, in addition, injury of the brain substance. Or it may, and probably is, in such cases as recover consciousness within a reasonable period, be simply due to a sudden severe shock to the centre of vitality, the medulla oblongata, the complete unconsciousness being due to the suspension of the functions controlled by the nœud vital. The examination of the skull and lower jaw will show that the long axes of the condyles of the jaw being prolonged backwards will meet at the basion, the centre of the anterior border of the foramen magnum.

Immediately in front of this point the medulla is situated, and the issuings of the pneumogastric, glossopharyngeal, spinal accessory and hypoglossal nerves are closely adjacent.

Now, a blow delivered on the point of the jaw or slightly to either side of the point would be directly transmitted upwards along the thickened oblique ridges to the rami and thence to the condyles, and in consequence of their oblique direction backwards and inwards, the force from either side would centre directly at the important point of the basion. I believe this will explain the temporary annihilation of consciousness from the terrible blow. The injury has fortunately only been occasionally fatal, and, as this case would indicate, when only fracture complicates the shock to the nervous system.

In my other case the injury was more severe, a portion of the left petrous bone being driven inside the skull. There was no escape of blood into the pharynx, and the case was further complicated by a fracture of the occipital bone by a fall on the pavement. The man died during removal to the hospital, a distance of 100 yards or so. It was, in fact, a distinctly accurate "knock-out blow" deliberately inflicted, and the death could only have been due to the sudden and severe direct shock to the brain, *i. e.*, the medulla. Post-

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mortem, but little hæmorrhage was found, and that only superficial.

There was no reason to suppose that the injury in the first case was anything but the result of a clumsy "upper cut" given by a man unaware of his own strength, but it well illustrates the danger of such a blow, and by how much the more dangerous when given with skill and deadly intent.

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# Selected Article.

## BLISTERS IN PNEUMONIA.*

By JESSE EWELL, M.D., Ruckersville, Va.

When I announce my subject to be "The Use of the Blister in Pneumonia," I feel that, at once, you regard me as an unqualified crank; or, at least, a Rip Van Winkle of no recent type.

That I came from, or near the mountains, is true; and that I champion a remedy almost as old as the hills, is equally true; and still it is a conviction, on my part, that my medical brethren are allowing a most valuable remedy to lie idle; that brings me to the front to claim for a short time your kind consideration and attention.

There can be no doubt that the Cauthidal Blister was in general use in the profession one hundred years ago, and to-day it is used only by a few *moss grown* individuals like myself. This, to many minds, is *prima facie* evidence that, being "no good," as a remedial agent, it has been consigned by the profession to oblivion. I deny this impeachment, and, as an example to the contrary, I would point out the to-day fashionable cold water treatment of Brand. This was no new treatment one hundred years ago, for James Currie (a friend of Burns and editor of his poems) wrote his medical reports on the effect of water, cold and warm, as a remedy in fevers and other diseases. Vincent Priessnietz, the founder of hydropathy, was a German, and, though not a doctor, is said to have treated three thousand patients in two years, and only lost two cases. Yet, after cold water had been tried for many years by the profession, it was laid aside, to be brought to the front again by Brand; and is so popular to-day that I think some of the younger members

* Read by title at request of author before the Medical Society of Virginia, during its Fairtieth Annual Session, in Richmond, Va., October 21-26, 1899.

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of our profession seriously contemplate laying aside the time-honored saddle pockets, the insignia of the country doctor, and go armed simply with a watering-pot and a rose sprinkler.

Since we have concluded that pneumonia is a germ disease, it is especially easy to spend our time in bacteriology, and lose sight of the fact that we have inflamed lung to treat, regardless of what may be the cause of the inflammation. When the hurried breathing, short cough and high temperature assures us of this fact, the application of a blister will often work wonders.

In the language of the older writers, I will say that "blisters draw both the nervous and circulating fluid to the seat of their own immediate action, and thus relieve irritations and inflammations of the internal parts;" and I agree with them in thinking that the serous discharge results in the unloading of the inflamed parts in close proximity.

I know the old writers drew fine lines as to the proper time to apply a blister in pneumonia; my own experience, and that of my medical friends who blister at all, would lead me to say, without hesitation, that the proper time is just as early as possible. As soon as you find you have a case of pneumonia to treat, blister at once; and oftimes, on your second visit, you will find that a third visit is not required.

If, however, as is sometimes the case, the disease refuses to yield to this rude onslaught, examine the chest again carefully, and it may be you will find inflamed lung tissue at some point too remote to be benefited by the blister you have already applied. When such is the case, do not hesitate to apply as many blisters as would seem to be indicated. However, as the effect of a blister is to reduce both the temperature and pulse (and sometimes both drop), I rarely apply a blister larger than 6 x 6, though I often order that, when removed, it shall be applied to some other part of the chest, and have thus drawn as many as three blisters on a patient in twenty-four hours. As ugly as a raw blister looks, and however much the patient and friends may object to its first application, there the opposition ceases, and I have had patients to call for the blister to be applied.

That a blister may add to the irritation, and thus excite additional inflammation and make your patient worse, there can be no doubt; but this is the fault of the treatment which the blister receives rather than the fault of the blister itself. My plan is this:

I use the blistering plaster, or ceratum cantharides, U. S. P., which I spread on a piece of cloth of suitable size,

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and usually cover the face of it with very thin gauze. While the gauze retards the action of the plaster to some extent, it is of use in preventing any portion of cerate from adhering to the skin when the plaster is removed, to which is sometimes due the strangury which follows a blister. Strangury but seldom occurs, and may be prevented in subjects especially liable to it by the use of demulcent drinks, beginning with the application of the blister. The skin should be free from grease, and should be wet with spirits of camphor, which is supposed to lessen the tendency to strangury. A compress and light bandage will hold the plaster in position. The directions to the nurse are—to wait from two to four hours, as may be most reasonable, and then only raise one corner of the plaster, and if fine watery vesicles are to be seen, to remove the plaster and apply dressing. When no vesicles show, press the corner of the plaster back and examine again in from thirty to sixty minutes, until it is ready to come off. If doubt rests on the mind of the nurse as to whether it has drawn enough, let it remain till there is no longer a doubt.

Then comes the dressing: I direct that all dressings should extend at least one inch beyond the edge of the blister all around, so that if it should slip a little the blister will not be exposed to the air. I prefer to first dress it with cabbage leaves, or with the leaves of the wide leaf plantain; and these should be softened by dipping in hot water and laid on the blister several layers in thickness; a compress and bandage completes the dressing. These leaves should be exchanged for fresh ones every four hours, and always applied as warm as is comfortable. They develop up a better blister than any other dressing, but if not obtainable, a poultice may be used from the first. When a sac forms holding as much as half a drachm of serum, it should be carefully opened with scissors or needle.

After twenty-four hours I direct the leaves to be laid aside and a poultice to be used instead. This should be made of fresh milk, thickened with flour; it should be thin enough to pour into a bag made of soft white cotton and the end sewed up to prevent the contents from escaping, and the side to be applied to the blister well greased with hog's lard.

These poultices require to be changed every six to eight hours only, but should not be allowed to sour or to get cold and stiff. When patient has been convalescent for thirty-six or forty-eight hours, the blisters may be healed by the application of simple cerate on a cloth. Before one dressing

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is removed the other should be ready and waiting, as air is painful to the raw surface and should be avoided. Sometimes a blister heals under the dressing before the patient is convalescent; when the tendency is in this direction, you can re-apply plaster for ten to thirty minutes, or a little blistering salve may be mixed with three times its bulk of lard, and used to grease the poultice once or twice.

All this detail may be very tedious, but I think it worth remembering.

I practiced medicine for years before I ever used a blister, but now I agree with a good many of my older brethren, and believe that a blister in pneumonia gives the patient the best chance to get well. I do not rely on blisters alone, but use such other remedies as are commonly used by the profession. But when I see in a newspaper, as I often do, that such and such a life (a bright one perhaps) has gone out, another victim to pneumonia has been laid low, I often wonder if a blister has been used. Should I lose a patient with pneumonia without having applied the blister, my conscience would tell me I had not done my duty.

Now, I have no statistics to offer you, for country doctors do not keep records of their cases as they should, but I find no patient too young and none too old to be treated and benefited by the blister. And, laying aside my modesty for the moment, I can boast of the recovery of as unfavorable cases as falls to the lot of any one, and these recoveries are due, in a large measure, to my creed, "In pneumonia, blister early and often."—*Virginia Medical Semi-Monthly.*

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# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.
Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine University of Bishop's College; Physician Western Hospital.

### THE FAILURE OF ANTISTREPTOCOCCIC SERUM.

DR. WM. CLARK in Cleveland *Medical Gazette* writes as follows on the subject;

With the advent of antidiptheric serum and its successful place in the therapeutics of the majority of the profession,

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came the attempt to produce serum for the cure of that class of diseases caused by streptococcic infection ; and great hopes were entertained that we had at last found a remedy powerful enough to cure such diseases as puerperal fever, cerebro-spinal meningitis, etc., which have always been a thorn in the flesh.

During the past year reports have been published by the score from all parts of the country, some highly eulogistic of the serum and many reporting it valueless.

It has seemed to the writer that, in those cases in which a favorable report was made, too little was ascribed to the stimulating and antiseptic treatment of the physician, and too much to the serum. Upon the intelligent use of the serum is dependent its value. In some cases too little is used.

The writer has noticed in many of the reports of cases in which this remedy was used an utter disregard has been paid to ascertaining whether the cases were of streptococcic infection or not. Particularly was this true in reports of puerperal fever and cerebro-spinal meningitis. In puerperal fever a sterile swab should always be introduced into the uterus and smears taken for examination, while in cerebro-spinal fever, lumbar puncture should be performed, and the serum examined for the active disease-producing agent. If then, the streptococcus is found to be the cause of the disease, the serum can be used with some prospects of success.

When we reflect that in puerperal fever the woman may be infected by the colon baccilus, Klebes-Loeffler baccilus, scarlet fever, erysipelas and the various pus-producing organisms, and that in spinal meningitis of a typical form the condition is not produced by the streptococcus but by the diplococcus intracellularis, meningitis of Weichselbaum, we can readily see how ineffective this agent might be in those cases. It has come to be a conceded fact that there are kinds and classes among the chain-baccilli, just as there are kinds and classes among all other things ; and the serum made from one kind of streptococcus is no more a protective against ravages of another kind than antidiphtheretic serum is protective against yellow fever.

Undoubtedly there were some cases reported in which the serum was of value, and possibly of great value ; but they were cases of infection by the same kind of streptococcus as that used in producing the serum, and in which no general streptococcic infection existed.

One disadvantage in using this serum is its quick loss of power. Sometimes within a period of six weeks after its

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first production it has lost nearly all its efficacy. Another is the inability to form a correct estimate in the majority of cases of how much to use.

The writer deprecates the hit or miss method of using this agent—the giving of it on the presumption that if it does no good, it will do no harm—on the grounds that, first, it is not scientific, and, next, there is no remedy in general use to-day that could be discredited by the same general and indiscriminate use.

The writer holds the opinion that at present the value of the antistreptococcic serum is limited, but hopes that some time in the near future a serum will be made that will have the same definite value and results as that of anti-diptheretic serum.

## THE TREATMENT OF DIABETES MELLITUS.

The discovery by Claude Bernard of the glycogenic function of the liver apparently threw a flood of light upon the origin of this disease, and has dominated the treatment of the affection for the last quarter of a century, until within a comparatively recent period. The aim has been in all cases of glycosuria to eliminate starches and sugars from the diet and to keep these patients upon a strictly non-diabetic diet. Theoretically, this elimination was supposed to lessen the amount of sugar in the blood and thus lessen the toxemia.

The delightful simplicity of this theory commended it to therapeutists, but a study of considerable proportion of these cases in which starches and sugars have been almost eliminated from the diet has shown that they did not do nearly as well as those who were allowed a moderate amount of these substances. The further study of these cases has shown that the whole question in diabetes is not apprehended in the elimination of sugar. We have differentiated glycosuria, so-called, from diabetes, recognizing that the former is not nearly so serious a disease as the latter, but that no hard and fast line can be drawn between the two conditions, as there are cases which partake somewhat of the character of glycosuria and others of diabetes, while occasionally these conditions are interchangeable in the same patient. A further study of these cases shows that there are other elements than the mere sugar production which enter into the clininal picture. As a rule, the diabetic has an excessive appetite, with a craving for starches and sugars. This is due to the enormous elimination of sugar and a consequent demand of the system for water and for materials for the manufacture of sugar. Even if his diet is re-

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stricted in the matter of starches, he will still consume a larger quantity of food than the average individual. It may well be questioned whether the restriction of diet to protein substances is not beneficial, from the fact that it reduces the whole quantity of food taken. As a result of an ingestion of large quantities of food, there is frequently set up in the alimentary tracts of these patients fermentation, with occasional attacks of diarrhea, alternating with constipation, the latter being favored by the enormous watery drain from the kidneys.

The latter treatment of diabetes does not aim to cure the affection by eliminating starches and sugars from the diet. Undoubtedly the older writers believed that if all carbohydrates could be eliminated from the diet and kept out of it for a sufficient length of time the patient would recover. The latter conception of the disease regards all this as error, and looks upon all confirmed cases of the disorder as largely incurable, but which with medical attention will live for years leading fairly useful and comfortable lives. The main thing to be avoided by a diabetic is excessive consumption of food, by which the organs of digestion are overtaxed and their function disturbed. The diet should be a mixed one, in which the carbohydrates are considerably reduced, but in which they are not altogether eliminated. The quantity of food taken should be just sufficient to meet the needs of the patient; it should be apportioned carefully for each meal, and under no circumstances should the patient be allowed to over-indulge. Careful attention should be directed to the alimentary tract, and fermentation or the results of constipation should be carfully eliminated. In all severe cases in which there is alimentary disturbance, lavage of both stomach and bowels should be employed.

Medicinally there is comparatively little treatment, but antipyrin combined with bicarbonate of sodium does favorably influence the general condition of the patient, and has some action in diminishing the production of sugar. Iron and arsenic are useful as tonics, and liberal quantities of water should be allowed, which dilutes the urine and washes out the accumulated sugar from the blood.

## THE MEDICAL TREATMENT OF TUBERCULOSIS.

The *Journal of Tuberculosis*, July, 1899, contains the following résumé of Schulz's paper on this subject. In this age of rapidly extending lists of drugs and the preval-

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ence among the profession of a state of therapeutic nihilism in regard to their use, one is led to sympathize with the reaction against drug treatment when viewing the full extent of our capabilities in respect to their use in this wide-spread affection, and to realize that to a large extent in regard to our therapeutic resources generally, when antitoxin and surgery are not available, climatic and hygienic measures, hydrotherapy and probably electricity are the physician's chief resource.

Schulz, of Greifswald (Deutsch. Med. Wochensch., May 25, 1899) says that generally speaking the remedies used against tuberculosis vary little from one century to another. It frequently has happened that a remedy advocated by the profession has been discarded by the latter only to be taken up by the public.

Aside from a few synthetic chemical remedies and certain exotic newly discovered plants, the materia medica of phthisis is old. On account of the malignancy of tuberculosis the number of remedies which have been used in its treatment is of course very great ; but all of them may be grouped under two heads.

The first division is composed of remedies directed against the disease itself which have actually shown themselves to be possessed of real therapeutic efficacy.

The second group, on the other hand, comprises all substances which have no real efficacy against the disease, and which have been given oftentimes with intent to deceive the patient and encourage false hopes, and which through the influence of suggestion may appear to produce benefit at times.

The author attempts to enumerate all the articles of the materia medica which have been recommended for phthisis. For convenience he divides these remedies into two groups, one of which comprises such drugs as benefit the organism at large while the other is limited to remedies having special indications.

He enumerates drugs once officinal but now used only by the laity, and other plant products no longer thought of by physicians in connection with phthisis but which once enjoyed great favor among the members of the profession.

Some of the substances mentioned by him are agrimony, chelidonium majus, marrubium vulgare, pulmonaria officinalis, sticta pulmonaria, and so on through an endless list of plants, a number of which have entered into the formulae of secret remedies, popular " teas," etc.

The use of fats, including milk, for phthisis is old.

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Goat's milk, Kumyss, neat's-foot and olive oil, cod liver oil, etc., have all had extensive vogue in particular ages and regions, and the principle of using substances of this sort has become universal.

Among chemical alteratives which have been extensively used for phthisis are iodine, arsenic, mercurials, gold, sulphur, phosphates and hypophosphites.

Gases have been used medicinally by inhalation—oxygen, nitrogen, hydrogen, ozone—without any resulting advance in therapeutics.

The balsams so-called are of especial interest in the treatment of phthisis, and the Balsam Peruvianum is perhaps the best known in this connection ; the fact that its active ingredient cinnamic acid and its sodium compound are largely used in the treatment of phthisis through the labors of Landerer is regarded by the author as a step in the direction of national therapeutics.

Tar and creosote and allied substances enjoy a wide vogue in the treatment of phthisis at the present time.

Schulz now comes to the discussion of serum therapy and organotherapy. Under the former head tuberculin and several sera have been extensively tried, including the use of extracts of lung tissue.

The author next discusses those remedies which fulfill a single indication such as expectorants, haemostatics, antihydrotics, antipyretics, etc., etc. Under expectorants, antimony and other nauseants, and sal ammoniac are mentioned. For haemoptysis an endless number of remedies has been used without any exhibiting special excellence. For colliquative sweats a large number of remedies has lately been brought forward, such as thallium acetate, chloralose, camphoric acid, cotoin.

Most of the remedies in use against phthisical diarrhoea are old—bismuth, opium and astringents.

Antipyretics have been used in great variety. This group includes quinia, salicylic acid, benzoate of soda, alcohol. They were not very successful in bringing down the temperature, while the more modern antipyretics, however effective, are not adapted for continuous exhibition.

Schulz concludes by saying that when all these curative and symptomatic remedies fail to yield a hopeful result, we have to prescribe for the pain, and to that end must make use ofnarcotics, sedatives and hypnotics.

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## THE RELATIVE TOXICITY OF COCAINE AND EUCAINE.

Dr. H. H. Peck (*Journal of the American Medical Association*, September 9th) says that his experiments lead him tothe following conclusions:

1. The action of cocaine is inconstant; one never knows whether the symptoms occasioned by like quantities of the drug, in animals or individuals, under like circumstances, will be similar or dissimilar.

2. The action of eucaine is constant. The symptoms occasioned by the use of like quantities in animals under like circumstances, and, so far as the author's experiments have gone, in different individuals also, are the same.

3. The first action of cocaine on the heart is that of a depressant, and on the reepiration it is that of a mild stimulant, the after-effects being, on the heart, that of a decided stimulant, and, on the respiration, that of a decided depressant.

4. The first action of eucaine on both the heart and respiration is that of a stimulant, the after-effects being those of a decided depressant.

5. Cocaine causes death in animals by paralyzing the muscles of the respiratory apparatus, the heart's action continuing in a feeble way for a brief period after breathing ceases.

6. Eucaine causes death in animals by paralyzing the muscles of the heart and of the respiratory apparatus, which cease to operate simultaneously.

7. Eucaine in toxic doses nearly always causes nausea, and occasionally vomiting.

8. Cocaine is much less nauseating and scarcely ever causes vomiting.

9. Eucaine is decidedly a diuretic, causing renal discharge in a majority of instances in which a toxic dose is used.

10. Cocaine is not a diuretic to any appreciable extent. renal discharge having occurred in only one instance in connection with all the author's experiments.

11. The pupils of the eyes, in nearly all cases of cocaine poisoning, do not respond to light, and the eyes are more or less bulging from their sockets.

12. The pupils of the eyes, in most cases of eucaine poisoning, do respond feebly to light, and the eyes rarely bulge from their sockets.

13. The action of toxic doses of eucaine is more like that of a paralyzing, tetanoiding, convulsion producing agent

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than of an anæsthetizing one, the plantar and cremasteric reflexes nearly always responding.

14. Toxic doses of cocaine cause general anæsthesia in connection with the other symptoms in the majority of cases.

15. True tetanus of all striped muscles of the limbs, and Cheyne-Stokes breathing nearly always occur with the use of cocaine, but seldom does either occur when eucaine is used.

16. Cocaine is at least three times more toxic than beta eucaine, and alpha eucaine is as toxic as cocaine.

17. Boiling does not destroy the efficacy of cocaine, but it does modify it, and boiling in no degree lessens the efficacy of eucaine.

The above deductions have been made only after many experiments in connection with each individual point. The author has observed many interesting features in connection with the relative worth of these drugs as local anæsthetics, but his paper does not treat of this phase of the work. There is much experimental work yet to be done in this connection, the results of which he will present at some future meeting. *N. Y. Med Jour.*

## DIET IN TYPHOID FEVERS.

By FRED C. SHURTLEFF, M.D., Los Angeles, Cal.

Much has been written both *pro* and *con* in reference to this or that article of diet in the management of typhoid fever. It is a settled fact that the food must be fluid, highly nutritious and easy of digestion, for the maintenance of nutrition is imperative in this wasting disease. Milk is probably the most extensively used, and will form the main article of diet so long as fever lasts. I have used milk in nearly all its various forms in the care of my cases, from frozen or boiled sweet milk to butter milk, from sweet milk, milk with lime water, to that partially digested with pepsin or pancreatin when digestion was enfeebled. The tendency in milk diet is to overfeed by forcing too large quantities at one feeding, and thereby cause a disgust for that diet upon which we have pinned our faith. If one insists upon an absolute milk diet, not infrequently will you find your patient has gone without it rather than take it. They fret under its administration, digestion is interfered with, curds swarming with bacteria of decomposition are found in the increased diarrhœal discharges, plus the bacteria of typhoid fever already existing, hence the object which we wish to attain so far as it is possible (that of rendering the gastro-intestinal tract aseptic) is defeated from the outset by error in diet. I have often been puzzled as to what to substitute for milk in this class of cases until the stomach became more tolerant. I have tried various farinaceous substances, and discarded them on account of the increase of flatulency they almost invariably produced.

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For some time past I have tided my patients over their critical period by tablespoonful doses of liquid peptonoids every two hours, giving nothing else in the way of nourishment but the above remedy. I cannot speak too highly of this elegant preparation where digestion is below par as a highly nutritious food that will not curdle upon the stomach, or leave a residue in the intestinal tract. It is a slightly stimulating food, consequently your cases as a rule will require less alcoholic stimulants, a great desideratum in some cases. I do frequently carry through my cases of typhoid successfully where no other article of diet is given from the time I make the diagnosis until convalescence is firmly established, and I call the attention of the profession to it for that class of cases in which milk cannot be taken.—*Southern California Practitioner.*

## HEROIN TO RELIEVE COUGH AND CHEST-PAINS IN TUBERCULOSIS.

Dr. A. W. Beketoff (*Amer. Jour. Med. Sci.*, August, 1899) has made use of heroin in the treatment of twenty-five patients suffering from tuberculosis, in dose of one-tenth of a grain in powder or pill. In about fifteen minutes after its administration cough ceases, and sleep is possible. The respiration, especially when increased by coughing or pleuritic pain, is slower and deepened. In case of disease of the heart, or oxygen-hunger from encroachment upon the respiratory area (large cavities), this remedy is of little or no value. It has but little influence upon the circulation as regards either frequency or fullness further than that respiration is benefited. It relieves chest-pain, and so favors sleep. Insomnia due to mental excitement is not markedly relieved. It is well borne, even if digestive disturbances exist. It is indicated in the treatment of hemoptysis because of its beneficial action on cough. Patients do not become readily accustomed to its action, and it may be administered for a month without necessity arising for increase of dose.—*Virginia Medical Semi-Monthly.*

## TREATMENT OF MIGRAINE.

Dr. Henry Hanford, in an article on migraine and the vasomotor theory, speaks of the treatment as follows: "It is well known that when, with headache the extremities are cold, some relief is obtained by warming the hands and feet at the fire. In many cases the recumbent position is required in addition. In a large class of patients the attack may be cut short by many hours by going to bed, applying hot bottles to the extremities, and taking a hot drink (as soon as the stomach will retain it)—some hot tea or milk. A glow

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soon pervades the surface, and the spasm is relaxed. Relief so obtained is not very liable to relapse. After a few hours the ordinary duties of life may be resumed, and, although sleep is the best completion of the cure, its place may sometimes be taken by a good dinner. I believe this treatment, when it can be carried out, to be far superior to any drug treatment, although it may be aided by a good dose (thirty to sixty grains) of bromide potassium. It is a curious fact, and may be taken as the exception which proves the rule, that a few patients find that the recumbent position aggravates their pains, and often prefer to spend the night in an arm chair rather than go to bed. And also, in the last stages, moving about sometimes seems to hasten the end of the attack more than remaining quiescent."—*Edinburgh Medical Journal.*

## BLOOD-LETTING.

The backward swing of the pendulum is somewhat anticipated in regard to bleeding by Briscoe in the *Clinical Journal* for the September issue.

He states that the condition of the system indicating blood-letting is expressed by the word suffocation.

Local conditions may require bleeding as alveolar abscess, ordinary inflammation, chronic inflammation, thecal abscess or any tissue requiring the relief of tension.

He states that every surgeon should carry some kind of venesector in his pocket.

The states of the general system denoting venesection are included in the following conditions:

When you find the venous system gorged in primary affections of the lungs or in the secondary congestions, as in heart disease, or from paralytic conditions, as in apoplexy, you cannot be wrong in bleeding; you relieve the venous system as well as the heart, and allow the circulatory apparatus to right itself. The objection sometimes made that the patient is too weak, as indicated by the pulse, is futile, since, owing to the small amount of blood which reaches the left ventricle to be propelled onwards, the pulse is naturally small.—*Charlotte Medical Journal.*

## THE SERUM TREATMENT OF TYPHOID.

A London correspondent of the *Interstate Medical Journal* for July writes that the main point of interest centres round the serum-treatment experiments which are being conducted in different parts of the world. One of the late com-

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missioners, Prof. A. E. Wright, of the Army Medical School, Netley, took advantage of his visit to the typhoid districts of India to avail himself of the opportunity of inoculating certain British troops against this dread enemy of the soldier on foreign service. It appears that in the "West Riding" regiment, stationed at Bangalore, 250 of the soldiers volunteered to be inoculated with the typhoid serum as a protectionary or prophylactic measure. When at Rawal Pindi, Dr. Wright addressed the "Queen's" regiment on the advantages of inoculation, mentioning that 1,500 soldiers annually fell ill with enteric fever, and that one out of five dies. Out of 200 attendants at the Maidstone Asylum in Kent in the south of England, ninety-five persons were inoculated and none contracted fever, while of those who refused to undergo the process nineteen suffered from the disease. At Khartoum, of eight young subalterns six consented to inoculations, and the other two agreed to take their chance; of these latter, one was very ill with typhoid, the other died; the inoculated officers escaped. Professor Wright also inoculated the troops in garrison at Lucknow, 300 of the Third Hussars and 120 Cameronians. Diligent experiments are being made with the typhoid serum in more than one physiological laboratory in this country.—*N. Y. Med. Jour.*

# SURGERY.

IN CHARGE OF
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AND
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## OPERATIONS IN GASTRIC ULCER.

Dr. Leonard A. Bidwell (*American Journal of Medical Sciences*, September) recapitulates as follows the class of cases of gastric ulcer in which an operation should be done: 1. In all cases of perforation at the very earliest possible moment; also in subphrenic abscess. 2. In cases of hæmorrhage (*a*) when there is continual oozing of blood, especially if the stomach is dilated, and (*b*) in cases of repeated severe hæmorrhage. 3. In cases where there are severe pain and vomiting unaffected by treatment, and which are producing progressive emaciation. 4. In cases of dilatation of the stomach from contraction within or from adhesions outside

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the stomach. The operations to be performed are: In class 1, laparotomy and suture of the ulcer; in class 2, gastrotomy and suture of the ulcer with a purse-string suture, combined with gastro-enterostomy; in class 3, gastro-enterostomy, in order to give physiological rest to the ulcer; and in class 4, either gastro-enterostomy, or, if the pylorus is affected, pyloroplasty or pylorectomy. As the surgery of gastric ulcer is a comparatively new subject, the author has had, so to speak, to make a case in its favor. It has been his endeavor to show that no patient ought to be allowed to die either from perforation or from hæmorrhage from a gastric ulcer without a surgical effort being made to save him; that the earlier such effort is made the better the chance of success, and, finally, that surgery offers much hope of success in other cases which resist the art of the physician.—*N. Y. Med Jour.*

## THE SPHERE OF DRAINAGE IN SURGERY OF THE APPENDIX.

W. S. McLaren divides cases of suppuration about the appendix into two classes: the first comprises those in which the abscess is localized, being shut off from the general cavity by adhesions; the second includes those more serious cases in which the pus has entered the general abdominal cavity. Cases of the first class are simple abscesses, and should be treated like abscesses of any other region. In these cases drainage is a perfectly proper, though sometimes unnecessary, procedure. In cases of the second class drainage is irrational, because it does not drain and because any foreign body must add to the already-existing irritation. Filling the abdomen with saline solution is considered to be rational, because it dilutes the poison which is generated during the few hours immediately following operation, and vastly increases the area of the peritoneum, which is called upon to resist that poison. Two cases are reported in which this method was used; there was an abundance of pus in the general cavity, which was washed out with peroxide of hydrogen; the abdomen was then filled with saline solution and the abdominal incision closed. Both patients made good recoveries.—*N. Y. Med. Rec.—Med. Review.*

## THE PREPARATION AND AFTER-TREATMENT OF CHILDREN FOR OPERATION.

By FREDERIC N. WILSON, M.D.

Much has been written in our text books and by numerous other writers of the general and special technique

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of operations upon children, but the preparation and after-treatment, except in a very general way, have been rather neglected. It is with the object of urging greater care and consideration of these points that this paper is written.

The two most important dangers to be avoided are dietary disturbances and hemorrhage. I place the dietary disturbances first, because they are very often the most difficult to overcome. When it is possible to select the season for operation, cool weather should be our first choice, for less gastro-intestinal disturbance may be reasonably expected then. It is of the greatest importance when a child is not taking its feeding well, or its food is not agreeing with it, as evidenced by vomiting or diarrhœa, or both, or loss of weight, that some modification should be made and a diet found which the child will retain and digest, so that after operation we are likely to be spared the necessity of further experimenting in that direction. In breast-fed babies clock-work regularity in feeding will, with perhaps a little temporary medication, place the patient in suitable condition. In bottle-fed babies I have seldon found one who could not take and digest some one, or two alternating, of the following preparations:

I. *Egg-water.* The white of one egg to four (4) ounces boiled water, to which is added ♏xv aromatic spirits of ammonia.

*For older children:* The whites of two (2) eggs to six ounces of boiled water; add ♏xxv aro. spts. amo.

II. *Fresh condensed milk* in the proportion of one (1) part with ten (10) to one (1) part with six (6) of boiled water, the proportions all depending upon the age and digestive ability of the child.

III. *Sterilized milk.* Temperature of 212° F., for fifteen (15) minutes.

IV. *Pasteurized milk.* Temperature 170° F., for fifteen (15) minutes.

V. *Peptonized milk.* The cold process is preferable, the result being less bitter. To a pint of fresh milk is added soda bi-carb. gr. x. Ex. Pancreatin gr. v. The process of peptonizing is allowed to continue for three (3) or four (4) minutes, the milk is then placed on the ice to stop the process. When the milk is warmed for consumption it becomes still further peptonized.

VI. *Top milk, barley malt water,* sterilized water, equal parts. The barley malt water is prepared in the following manner:

To two ounces of barley (Robinson's preferred) is added

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30 ounces of water, boil ten minutes, then add 26 ounces of cold water in which has been dissolved half a teaspoonful of extract of malt. This is allowed to stand 15 minutes, is then heated again for 15 minutes, and after straining is ready for use.

VII. *Mutton broth.*

VIII. *Expressed beef juice* in proportion of one (1) part with four (4) to one (1) with eight (8) of boiled water. This often slightly increases the number of stools.

If the mother's milk is sufficient in quantity and quality. breast feeding should be insisted upon, provided the child is able to nurse, some cases of hare lip and cleft palate being the chief exceptions.

There being no food for nursing babies so good as breast milk, provided the child does well upon it, it certainly would be most irrational to change the feeding at time of operation, when it is to be expected that for a few days at least digestion is going to be a little below par. The gastro-intestinal tract can often be placed in a more receptive and tolerant condition by one or two washings of the stomach with warm boiled water, at a temperature of 105°, to which has been added a few grains of soda bi-carb and soda borate. This may be combined with rectal irrigations with warm water, containing a little soda borate, or with normal saline solution. During these few days of preparation when the condition and disease will admit of such a delay, the patient should be kept out in the open air as much as possible, provided the weather is suitable, and it is only in cases of pulmonary complications with the weather cold and damp that confinement to the house is to be recommended. A high temperature, except in these pulmonary cases, is not a contra-indication to out-door life; in fact, I believe it is actually indicated, provided the child is properly clothed. Very young children do not stand hemorrhage well; but, aside from an attempt to get the patient in the best possible general condition, there is not much to be done in the way of preparatory treatment. Some have advocated the intra-venous injection of normal saline solution before operation, but this procedure seems to me rather to favor bleeding by distending the blood vessels and also by increasing the blood pressure. If the saline is used before operation it is preferably introduced high in the bowel in small quantity, when absorption will take place as the blood needs it.

The examination of the urine, a procedure often neglected in children, is quite as important as in adults, for the knowledge of an unexpected kidney lesion might often

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modify the course pursued at time of operation as well as the anaesthetic used.

The immediate preparation of the patient should be quite as carefully carried out as in the adult, though in a rather less vigorous manner. Shaving, not so much with the idea of removing hair as with that of removing the superficial epidermic scales, should always be done. The skin should then be thoroughly washed with green soap, using a piece of ordinary gauze; this is then carefully washed off and the skin is ready to receive the mascerating poultice. In my experience green soap has often proven too irritating, and I now use white castile soap rubbed into wet gauze and applied for six to eight hours. This gauze is then removed, the skin washed with plain water, followed by alcohol and then the bi-chlorid gauze poultice 1-1000 is applied. This is allowed to remain till the patient is on the operating table. There the same washing with soap, this time green soap being used, followed by alcohol to thoroughly remove the soap and fat, and then bi-chlorid complete the preparation of the field of operation. Ether, so often used to remove the soap and fat, I have discarded since once seeing a baby collapse immediately following the pouring of ether over the abdominal wall. The child's bowels are best emptied by a soap enema four hours before operation.

The time of giving the last feeding varies with different men, and has seemed to me often to be too far removed from the time of operation, and it has been my practice to give a child solid food eight hours before operation, or, if an infant, milk five hours before and plain beef soup two hours before. Hot soup is readily absorbed by the stomach, furnishes additional fluid for the blood, is decidedly stimulating, and in my experience has never complicated the anesthetic.

On the table, I cannot too strongly urge the necessity of protecting those portions of the body not immediately concerned in the operation with dry wraps of flannel or cotton. In operations below the chest a flannel shirt should always be worn and kept dry, the limbs wrapped in cotton and bandaged. Dry sterilized towels are always to be preferred to wet antiseptic. Many patients, adults as well as children, taken from a warm bed, placed upon an operating table, given an anaesthetic which lowers the body temperature, covered with wet towels, allowed to lie in a bath of irrigating fluid without any attempt being made to keep the body temperature up, have been sent back to bed suffering from shock which might have been avoided by protecting the body with warm dry clothing. Why we should expect a sick person breathing a temperature-reducing gas to withstand

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such influences, which would be trying, to say the least, to a person in good health, is beyond comprehension; and I am very sure the number of cases of pneumonia, nephritis and death which can be justly charged to this lack of care must be very considerable.

The immediate after-treatment consists in stimulation of heart and keeping up of body temperature. Strychnine and caffeine head the list of drugs, while hot normal saline solution supplies heat and fluid. If the abdominal cavity is open and the patient is in need of stimulation, there is no method so quick and effective as to pour into that cavity a quart or more of hot sterilized normal saline solution, temperature 115°. If we cannot use this method, the high rectal irrigation, preferably continuous or as an enema, of saline solution at the above temperature is advisable for those cases where infusion cannot be done. The difficulties of doing an intra-venous infusion in a small child are not imaginary. To the hot rectal enema one to four ounces of strong coffee is often a valuable adjunct.

The child once in bed (the foot of which may be raised to increase the cerebral blood supply if necessary) should be wrapped in a warm flannel blanket carefully pinned so that no portion of the patient can possibly become uncovered except the face. The object of the flannel blanket applied in this way is two-fold; first it prevents loss of body temperature by radiation, flannel being a poor conductor of heat, and second it guards against the possible immediate contact of hot water bottles which, in spite of the serious and painful accidents which have occurred from their use, I consider a very valuable means of supplying heat, and I heartily recommend it. The distressing burns which have not been infrequent have always been due to carelessness and lack of attention, and I see no reason to condem a method, as some have done, when the fault lies altogether in the unskillful application of it.

Vomiting, which so often complicates convalescence, is best treated by withholding all feeding by mouth until the stomach is in condition to digest food. I have found teaspoonful doses of hot water, plain or with essence of peppermint, decidedly carminative, and all my cases receive this at first whether they vomit much or not at all. If vomiting is long continued, even this is stopped, the patient's mouth kept cool and clean with diluted solution of listerine, a mustard paste, 1 to 8, placed over the epigastrium, and food and fluid supplied by rectal feeding.

Peptonized milk, liquid peptonoids, and normal saline

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solution have in my hands proven to be the most satisfactory. Whether the child vomits or not, the first food it receives by mouth is either mutton broth or egg water, for I have found these to give rise to less disturbance than milk in any form, and it is only when I feel sure the stomach is capable of digesting the latter that I give it, and then very cautiously at first. In the after-treatment, as well as preparation, I consider fresh air of great value, and as soon as all danger of pulmonary trouble, *i. e.*, either bronchitis or pneumonia, is over, I send the cases out of doors at least a part of every day provided the weather is suitable, care being taken to see that the flannel underclothing is worn, light or heavy, according to the atmospheric temperature.—*The Post-Graduate.*

## THE PREVENTION OF POST-OPERATIVE THROMBOSIS IN THE VEINS OF THE LOWER EXTREMITIES.

The author directs attention to the occasional occurrence after certain operations on the abdomen, such as laparotomy, resection of the appendix, and the radical cure of hernia, of thrombosis of the superficial, and it may be also the deep veins of the lower limb, which thrombosis is frequently observed in the trunk of the femoral vein, and may extend into the external iliac vein. This complication, which, when it occurs, usually presents itself in the second or third week after an operation which in other respects has, as a rule, been most successful, cannot fail to cause anxiety on account of the risks of embolism of the pulmonary artery, and of pulmonary infarction, and necessitates an unduly prolonged confinement of the patient in bed. The author holds that this thrombosis is not in most cases the result of infection, but that it is due either to retardation of the circulation in the veins of the lower extremities, or to local changes in the walls of these vessels. With the object of preventing this serious complication, the author makes it a rule in his surgical pratice, after every operation on the abdomen and for hernia, to elevate the lower end of the patient's bed. If the organs of the patient be absolutely or relatively healthy, the elevation need not exceed 4 inches, but should be increased for exhausted and anemic patients, and those already affected with varicose veins. In a case of an anemic patient suffering also from weak heart and varicose veins, or of one who has been previously affected with thrombosis in the lower extremity, the end of the bed is raised on wooden blocks each about 20 inches in height. The elevation, if in this degree disagreeable to the patient, should be commenced at 4 or 6 inches, and afterwards be gradually

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increased. If, after the operation, the blood tension be low, and the heart's action weak or irregular, the author would endeavor to increase the force of the circulation, and to strengthen the heart by subcutaneous infusion of salt solution, and by suitable tonic and stimulating medication. Much improvement is attached to high elevation of the foot of the bed, and such treatment is strongly advocated, not only in surgical practice, but also in cases,—such, for instance, as enteric fever, chronic entero-colitis, and chronic peritonitis,—in which an anemic condition, general exhaustion, and a morbid state of the blood, may favor the development of venous thrombosis of the lower extremity.—*Dr. Lennander, in Centbl. f. Chir. Brit. Med. Jour., Post-Graduate.*

## A NEW ABSORBABLE LIGATURE MATERIAL.

The author reports the clinical results of his experience with a new absorbable ligature and suture, which he finds to be absorbed a little more slowly than catgut, but to be capable of absolute sterilization. The ligature is made from the *ligamentum nuchae* of the reindeer by dividing it in the direction of its fibres The process of preparation is the following: Removal of fat in ether, soaking in juniper oil for 14 days, removal of oil with ether and alcohol, soaking for two days in a one-third per cent. sublimate solution; preservation in alcohol. Bacteriological examination and the clinical test of 83 major operations have proved the absolute sterility of this material, and that it is absorbed as soon as desirable. *Dr. Sneguireff. in Centble. f. Chir., Am. Jour. Med. Soc., Post-Graduate.*

## TREATMENT OF BURNS AND OTHER SURFACE WOUNDS.

In a recent issue of the *Railway Surgeon*, Dr. G. Archdall Reid states: "I venture to place before the profession a method of treating surface wounds so simple and obvious that I think it must have been tried before. Briefly, I do not place the surgical dressings on the wound, but on a light wire cage or support, which thus, while permitting them to afford protection, prevent them acting as foreign bodies. The wire support is easily manufactured. If the wound be on a flat surface—as the chest—a stout wire of suitable length is bent into such a shape that when placed over the wound it surrounds the latter, but rests everywhere on uninjured tissue. On this wire as basis is woven a wide network of lighter wire, so that a shallow dish of wire work, shaped somewhat

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like the wound, but larger, results. If the wound be on a limb a cylinder of similar wire work is made in two parts, which is hinged together so that the cylinder may be easily applied to or removed from the limb. The circumference of the shallow dish and the ends of the cylinder are padded by wrapping some soft material—carbolized wool, for instance—round the thick supporting wire. When in place the apparatus may be covered by any dressings the surgeon chooses, and is retained in place by strappings or bandages.

"On one detail of the treatment it is necessary to insist with the utmost emphasis, the surface of the wound must be kept absolutely clean. It should be gently sponged daily, twice, thrice or oftener, if necessary, with some mild antiseptic fluid, such as boric acid or weak (1 in 40) carbolic lotion. Otherwise the discharges coagulating on the surface form a cake under which pus is retained, and which proves in experience more hurtful than any other foreign body. In order as much as possible to prevent the discharges drying and caking, I usually cover the supporting cage with wet lint, and the whole with waterproof. If, in spite of precautions, the lymph does cake, it may be softened by soaking in olive oil and then removed."—*Interstate Med. Jour.*

## THE INTERNAL DERANGEMENTS OF THE KNEE.

The internal derangements of the knee may be classified as follows: (1) Loose bodies; (2) detachment or displacement of the semilunar cartilages; (3) enlargement with nipping of hypertrophied synovial fringes, and (4) elongation of the ligamentum patellæ. In all these derangements, except the last, it may sooner or later become necessary to open the knee-joint if a radical cure is to be obtained. Walsham believes that the knee-joint may be opened with a freedom equal to that of opening the peritoneum, but likewise an equal amount of care for strict asepsis should be taken in opening the joint as in the peritoneal cavity. He calls especial attention to the five following points: (1) Preparation of the patient, *e. g.*, rest in bed three days to a week previous to operation, with the limb in a splint, regulation of bowels, etc., and careful asepticising of the skin; (2) arrest of all hemorrhage; (3) accurate suture of the synovial membrane and capsule; (4) postoperative absolute rest for the limb; (5) early passive movements and massage. As to the treatment of elongation of the patellar ligament, it is best to transplant it further down the tibia by the use of an ivory peg.—*Interstate Med. Jour.*

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# Jottings.

In the Northwestern *Lancet* of 15th November, 1899, Dr. Fliesburg, of Minneapolis, published the report of fifty cases of membranous croup with 38 recoveries and 12 deaths. Of the fatal cases, two were instrumental, viz., one tracheotomy and one intubation. The treatment adopted in all cases was the same. It consisted of hydrochlorate of apomorphiæ, one fifth of a grain; calomel, twenty grains; bi-carbonate of soda, half a drachm. To be divided into twenty powders, and one to be given every hour dry on the tongue. Equal parts of turpentine, eucalyptol, carbolic acid and Cologne water, to be poured into hot water, letting the child inhale the vapor under a thin blanket made into a canopy. On the second day the powders should be diminished to every two hours. On the third day the improvement is nearly always so marked that they can be discontinued. Then give a mixture every three hours in appropriate doses for age, containing pilocarpine, codeine, hydrochloric acid and syrup of tolu. During convalescence give a tonic of iron, quinine and strychnine.

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When the os uteri is rigid and tense, try:

℞ Sol. cocaine, 5 per cent..... 1 drachm.
Atropine ..... 1 grain.

M. Sig. Apply to external os, and, if possible, to the inside of neck of womb.

In five minutes you will have a good dilatation, and the parts will lose all their rigidity, and labor terminate readily and without danger of laceration. Also applied to the perineum in rigidity, it acts most kindly. Applied to the rectum where there is a tense, hard sphincter ani, to prepare for exploration by speculum or finger, will greatly facilitate the operation and give comfort to the patient.—DR. BALL, *in Medical Brief.*

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Onions are a kind of all-round good medicine. A whole onion eaten at bed time will, by the next morning, break the severest cold. Onions make a good plaster to remove inflammation and hoarseness. If an onion is mashed so as to secure all the juice in it, it will make a most remarkable smelling substance that will quiet the most nervous person. The strength of it inhaled for a few moments will dull the sense of smell and weaken the nerves until sleep is produced from sheer exhaustion. It all comes from one property possessed by the onion, and that is a form of opium.—*Winnipeg Lancet.*

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THE
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# Editorial.

## THE WAR IN SOUTH AFRICA.

It is safe to say that we know vastly more about South Africa than we did three months ago. Aside from the general interest which we take from our British loyalty in the war now raging there, we have the special reason of being an active participant in it. For the first time in our history we have sent Canadian troops to assist the Mother Country. Their progress has been eagerly watched, and day by day the papers are searched to see if they have had their "baptism of fire." Active hostilities, we know too well, mean death to some and wounds to others. But there is as a rule in all wars an enormous death rate due to sickness, most of it being caused by malaria. It is therefore, a matter of interest to know the character of the climate where the war is now raging. The climate of South Africa is, according to all writers, one of the healthiest in the world. So far the engagements which have been fought have resulted in the loss of a large number of lives, and rendered thousands non effective from wounds. The general health of the troops has, upon the whole, been excellent, though at the time of writing we see reports of deaths due to enteric fever. Still, upon the whole, it would seem as if the present war might be largely free from that enormous death rate which so commonly has accompanied large armies in the field. This, if it turns out to be the case, may be attributed to the extremely healthy climate

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but also, we believe, to the great advance that has during the last twenty years been made in sanitary science.

As large numbers of the troops were immuned from enteric fever before leaving Britain and on the voyage out to the Cape, it will be an interesting fact to learn, as undoubtedly we will, how far the hypodermic injection of the anti-toxin has been successful. The configuration of South Africa plays an important part in making it a healthy country. It strongly resembles a series of steps. The Coast plateau is six hundred feet above sea level, the Southern Karoo is twelve hundred feet, the Central Karoo twenty-five hundred feet, and the Northern Karoo four thousand feet. That portion which borders on the coast is the least healthy for Europeans. In Cape Colony rain generally falls in the early winter. The first three months of the year are the hottest, but almost rainless. On the East Coast, where Durban is situated; rain generally falls in the summer. This is said to be the rule in the interior, where the winters are said to be clear and dry, with slight frost at nights. There is a great contrast between the climate of the Southern Karoo and the Coast plateau. In the former it is dry, with considerable variations in temperature. The mean maximum range of the thermometer is 87 F. in January and 36 F. in July. The Northern Karoo stretches to the Orange River, and has an extremely dry climate, the rain fall in some parts being only two weeks, and the general average about ten inches. "The Transvaal is an elevated plateau with a very healthy climate. Pretoria is at an elevation of forty-five hundred feet, and Johannesburg of five thousand feet above sea level. In spite of this elevation the summer heat in these places is very great, and dust storms are frequent."

As an evidence of its antagonism to epidemic disease, it is said to be one of the few portions of the world which never has had an invasion of cholera or yellow fever. It would seem, therefore, as if the present war might be free from epidemic enteric fever, dysentery and diarrhœa, which are truly called the scourge of armies. We need hardly point out how valuable this is to our forces, for it will largely confine the non-effectives to those who have unfortunately been wounded. Such a healthy climate will facilitate much to their recovery.

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## THE VEIL A CAUSE OF A RED NOSE.

Rosenbach, in the *Berliner Klinische* for October 9, 1899, states that abnormal redness of the nose is often due to wearing a veil in winter. The knowledge of this fact may prove useful to physicians when consulted for this disfigurement of the features, often a sore blemish where all else is beautiful. He says the discoloration is most pronounced at those points where the veil presses most on the nose. It is partly due to the mechanical action of the sharp and rough texture upon a sensitive skin, and to the watery vapor that collects within its meshes and prevents evaporation. Blood is thus driven from the tip of the nose to adjacent parts, whose blood-vessels in consequence become enlarged and conspicuous. This is aggravated if the veil is kept on when passing from a cold to a warm atmosphere. The alterations tend to become permanent the longer the veil is worn without airing. Sometimes the cheeks are similarly affected. The treatment consists in, of course, discarding the offending covering, and, for a time, sharp winds and great cold. If this is impossible, avoid going rapidly from a cold to a warm atmosphere. Gentle massage should be practised, and applications of a thin layer of lanolin, vaseline or cold cream. This should be followed by the dusting of the part with talc or starch powder. When the use of a veil is necessary, it should not extend below the nasal orifices, so as to permit the escape of watery vapor. It also should be light in texture and worn as loosely as possible.

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## INTERNATIONAL CONGRESS OF MEDICINE.

The thirteenth meeting of this Congress will be held in Paris, August 2 to 9, 1900. The French Executive Committee have issued a circular to the profession in Canada through their Secretary, Dr. J. T. Loranger, of Montreal, giving the terms of membership and the names and addresses of the secretaries of sections. Any physician may be admitted to membership on the payment of five dollars, which must be remitted to Dr. Loranger or Dr. Starr, Toronto, when a membership card will be sent them. It is advised

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that members when remitting should state the special section to which they desire to belong. Communications (title) should be sent to the secretary of the particular section to which it belongs before the 1st of May, 1900. The list of these is too long for us to publish, but the name of the one desired may be obtained from Dr. Loranger, Montreal.

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Every inhabitant of Montreal must have been struck with the number of foggy days which we experienced last autumn and early winter. The fog was unusually dense, and on several occasions might be admitted to have been not by any means a bad sample of a London fog. It was yellow in color and very dense—obscuring objects at a distance of a few feet. Such a condition of the atmosphere might, with activity on the part of the Civic authorities, be greatly ameliorated. Fogs cannot be done away with, but it is admitted that their character may be improved—they may be made white—and not allowed to become yellow and black. This can be done by the City compelling every factory to consume its own smoke. Montreal has become a great manufacturing centre, and has almost always a heavy cloud of smoke hanging over it. When in the city the atmosphere may seem clear, but cross to St. Lamberts, and view it from there, and one will see the dirty atmosphere we are compelled to inhale. This is a matter of very considerable sanitary importance. Fogs of any kind are serious to those liable to bronchial complaints, but, when the fog is mixed with millions of particles of coal dust, their seriousness is very greatly enhanced.

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The New York *Post-Graduate* says it will be a bad day for medical science when the skeptic ceases to exist. We are called upon to believe so many things and to accept them at once that many are commencing to hesitate before accepting everything as Gospel that is proclaimed by microscopists and bacteriologists. It is still thought by many, in spite of all that has been written, that it is at least doubtful if the origin of disease is to be found only in the initial activity of germs. This state of matters bacteriological

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has been brought about by the statements of Dr. George Wilson, of Edinburgh, in his address on "State Medicine" at the last meeting of the British Medical Association held at Portsmouth. In fact, he has raised a hornet's nest about his ears by some of his statements on bacteriology. In his address he stated that "bacteriologists are not sure of their tuberculous bacillus, and it is a moot question whether the bacillus which is found in milk, and which is labelled as the tubercle bacillus, is not cow dung bacillus. A distinguished bacteriologist has admitted it. I venture to reiterate it." Of course, Dr. Wilson's competency in this special matter is called in question, but, true to his national instinct, he does not seem loathe to take up the gauntlet which has been thrown down to him. Incidentally, Dr. Wilson calls attention of bacteriologists to the fact that, in his opinion, Jenners' great discovery of the preventative power of vaccination has really no proper analogy with many of the serum treatments to which it is sometimes said to bear a real analogy. This question is one of intense interest to the profession, and the fight will be watched with eagerness by both contending parties.

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# Book Reviews.

**A Treatise on Surgery.** By American Authors. Edited by Roswell Park, M.D., Professor of Surgery in the University of Buffalo, N.Y. New condensed edition in one royal octavo volume of 1262 pages with 625 engravings and 37 full-page plates in colours and monochrome. Cloth, $6 net; leather $7 net. Lea Brothers & Co., Philadelphia and New York.

This is a condensed edition of the two-volume form published in 1896, and the author has taken advantage of this opportunity to revise the work to date, making it a thoroughly modern text book reflecting the methods of teaching developed by large experience.

The great demand for the work in its two-volume form which greeted its first appearance in 1896 warranted the belief that a somewhat condensed edition in a single volume, and at a correspondingly lower price, would add to its popularity. It is no small task to gather a comprehensive and authoritative expression of modern surgical knowledge. The labor of condensing this large and exhaustive work has been splendidly performed, for with great discrimination the editor has culled the essential facts without in-

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the least endangering the value of the book by rendering it too concise.

That two editions of a work should be simultaneously extant is a novelty worthy of comment. Practitioners and many students desiring the fuller information in the two-volume edition will naturally prefer it, but the condensed edition maintains the convenient division into general and special surgery, and thus preserves the conformity of the work with the surgical courses rapidly becoming universal, and it will answer the needs of students as well as of those who desire a comprehensive and practical single-volume work on the subject. The reduction in price is proportionately much greater than the reduction in matter, and is an advantage which purchasers will appreciate, and one which has only been rendered possible by the exceedingly wide sale already achieved.

The illustrations are excellent and well selected. We predict new popularity for an already very popular book. R. C.

**Bacteriology in Medicine and Surgery.** A practical manual for physicians, health officers and students, by William H. Park, M.D., Associate Professor of Bacteriology and Hygiene in the University and Bellevue Hospital Medical College, New York. In one 12mo. volume of 688 pages, with 87 illustrations in black and colors, and two full-page colored plates. *Just ready.* Cloth, $3 net.

There was a time when every physician was held to be possessed of the whole body of medical knowledge. He knew in part, he pretended in part, and the rest was imputed to him. Not every physician can be a bacteriologist, nor is it desirable that he should, but he must know the science if he cannot practise the art. He must know the drift of the teaching and have a knowledge of the work that has been done and is being done in the laboratories, and its application to his business of preventing sickness and healing his patients. This book by Dr. Park teaches just these things. It contains in regular order all that a physician or health officer or student need know, and it has in addition a certain literary quality which gives interest to the reading and a sense of clearness which prevents the statements being either loose or inexact. The book is in no way a compilation, and one has the feeling that the writer by much labour has a just appreciation of the difficulties of the various processes so pleasantly described. To go over in review all the chapters would be to cover the whole field of bacteriology, and such cognate subjects as "Immunity," "Infection," "Disinfection" and the various relations of bacteria to disease.

The book is not large; it is cheap; it is easy to read; it conveys a correct impression, and is satisfying to all ordinary wants.

In the next edition "Symmetrically sealed" will not appear. There will be a reconciliation of the statement at page 104, what animal parasites have to do with syphilis and the description of Lustgarten's bacillus at page 311, and words like "autopsied" will not be employed. A. McP.

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**A Laboratory Manual of Physiological Chemistry.** By Elbert W. Rockwood, B.S., M.D., Professor of Chemistry and Toxicology in the University of Iowa. Illustrated with one Colored Plate and Three Plates of Microscopic Preparations. 5⅜ x 7¾ inches. Pages viii.—204. Extra Cloth, $1.00, net. The F. A. Davis Co., Publishers, 1914-16 Cherry St., Philadelphia.

The want of a trustworthy and reliable manual of Physiological Chemistry has long been felt by the average student. There are few text books of Physiological Chemistry that are adapted to his needs.

Dr. Rockwood's volume should fairly realize the student's expectations, for it is thoroughly practical.

The author has succeeded in bringing together, within a small compass, the essential facts of medical chemistry. These facts are embodied in three hundred and forty experiments. A great deal of space is devoted to the methods of analysing the various secretions and excretions of the body. The practical exercises have been selected with great care and judgment, those on the examination of the gastric contents being especially valuable and up to date.

Clearly, the author has done his best to impart accurate information through the student's own observation.

We refrain from pointing out some trivial errors, lest we should seem to disparage a carefully written book, which we trust will meet with the approval of all teachers of physiology, who consider the laboratory method of instruction superior to the didactic. A. B.

**Notes on the Modern Treatment of Fractures.** By John B. Roberts, A.M., M.D., Professor of Surgery, Philadelphia Polyclinic. Publishers, D. Appleton & Co., New York.

This excellent little volume is made up of a series of essays issued at various times by the author, subject to some alterations to bring them into accord with his present views. We fully agree with Professor Roberts that in no part of surgery is there more need for practical common sense methods, untrammelled by ancient therapeutic dogmas, than in the ever varying conditions in fractures. Many false doctrines in the treatment of fractures are exposed, and valuable suggestion made to facilitate diagnosis as the use of the open incision or the Röentgen rays. The importance of positive methods of maintaining apposition of the fragments, as by wire nails, wire suture and tenotomy, with substitution of a plastic plaster of paris splint for an ill-fitting manufactured wood or metal splint, is certainly to be heartily endorsed.

As a whole, the work is one showing much observation with original research and independent thought, which makes it very valuable to the practitioner, although hardly complete enough to satisfy students. Many useful hints are given to simplify the adaptation of splints and splinting, while emphasis is placed on the value of securing opportunity for frequent massage of the muscles of a fractured limb and of the useless applications of lotions. G.F.

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**Thorington, Refraction and how to Refract.** Including sections on Optics, Retinoscopy, the Fitting of Spectacles and Eye-Glasses, etc. By James Thorington, A.M., M.D., Adjunct Professor of Ophthalmology in the Philadelphia Polyclinic and College for Graduates in Medicine; Assistant Surgeon at Wills' Eye Hospital; Associate Member of the American Ophthalmological Society; Fellow of the College of Physicians of Philadelphia; Member of the American Medical Association; Ophthalmologist to the Elwyn and the Vineland Training Schools for Feeble-minded Children; Resident Physician and Surgeon Panama Railroad Co., at Colon (Aspinwall), Isthmus of Panama, 1882-1889, etc. Two hundred illustrations, thirteen of which are colored. Octavo, 301 pp., $1.50 net, cloth. P. Blakiston's Son & Co., 1012 Walnut street, Philadelphia, Pa.

In this excellent book on refraction Dr. Thorington gives, in an interesting and essentially practical manner, all that is necessary to enable the student of ophthalmology to obtain a firm grasp of this intricate branch of the science.

While the work is not voluminous, it is remarkably clear and complete, and, though intended for beginners, contains much information that is useful to older ophthalmologists.

It is especially of value to students in that the writer teaches dogmatically the known facts pertaining to the estimation and correction of errors of refraction, and does not wander off into long discussions on disputed points.

Dr. Thorington is to be congratulated on having set forth so clearly and systematically what is known about refraction at the present time.

G. H. M.

**Hygiene of Transmissible Diseases.** By A. C. Abbott, M.D. W. B. Saunders, Pub., Philadelphia. Price $2.00.

This is a most comprehensive hand book, strictly adhering to the title; it is not a general treatise upon hygiene, but treats of a special part of the subject—transmissible diseases.

The plates, especially the photogravures of the different specific organisms, are very good. The work is very concise, yet sufficiently descriptive. There is no overcrowding; everything is readable and to the point.

The subject of Quarantine is treated in a very terse and clear manner.

An up-to date description of all the transmissible diseases is to be found within its 300 pages, as well as the very best and most practical means of prevention.

It is a book which will commend itself to student and practitioner alike as being concise, yet supplying all important information sought after in a work of this sort.

A. J. R.

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**Physiology, A Manual for Students and Practitioners.** By Howard D. Collins, M.D., Assistant to the Attending Surgeon of the Roosevelt Hospital; Assistant Demonstrator of Anatomy, College of Physicians and Surgeons (Columbia University), New York, and Wm. H. Rockwell, jun., M.D., Assistant Demonstrator of Anatomy, College of Physicians and Surgeons (Columbia University) New York; Member of Association of American Anatomists. Series edited by Bern B. Gallaudet, M.D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons, Columbia University, New York; Visiting Surgeon, Bellevue Hospital, New York.

This volume is intended to meet the needs of medical students who, in the short time allotted to the study of physiology, are expected to assimiiate only the main facts of the science.

As an elementary text-book it will be found useful. Its style is clear, and the information it imparts is more reliable than that contained in the many cram books on physiology, which are so popular among students. Unfortunately, the work is not free from inaccuracies. Thus we are told that the change from fibrinogen to fibrin, under the action of fibrin-ferment, does not take place unless paraglobulin be present. Now, it is well known from the researches of Hammersten and others, that paraglobulin neither helps nor hinders coagulation.

On reading the volume through, we have found some ambiguous statements which no doubt will be amended in a future edition.

A. B.

**Musser's Medical Diagnosis.**—A Practical Treatise on Medical Diagnosis. For the use of Students and Practitioners. By John H. Musser, M.D., Professor of Clinical Medicine, University of Pennsylvania, Philadelphia. New (3d) edition thoroughly revised. Octavo, 1082 pages, with 253 engravings and 48 full-page colored plates. Cloth, $6.00, net; leather, $7.00, net.

To critically examine a work of over one thousand pages inside of two or three weeks is an impossibility by one largely engaged in general practice, and this is the position we find ourselves with regard to Musser's Diagnosis. We have, however, examined more of it than we thought possible when we began, so fascinated did we become. We read chapter after chapter, till well on in the early morning, and then felt reluctant to close its pages. This examination enables us to say that we regard it as one of the best works on Medical Diagnosis yet published. It is a complete practical guide to the modern science and art of diagnosis. To those members of the profession who have for even a few years been out of touch with modern clinical work, as conducted at our large city Hospitals, such a work as Musser's Medical Diagnosis is an eye-opener. It demands a place on the book-shelf of every one who desires to be a good diagnostician.

F. W. C.

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**The Surgical Diseases of the Genito-Urinary Tract, Venereal and Sexual Diseases.**—A Text-book for Students and Practitioners. By G. Frank Lydston, M.D., Professor of the Surgical Diseases of the Genito-Urinary Organs and Syphiology in the Medical Department of the State University of Illinois: Professor of Criminal Anthropology in the Kent College of Law; Surgeon in-Chief of the Genito-Urinary Department of the West-Side Dispensary. Fellow of the Chicago Academy of Medicine; Fellow of the American Academy of Political and Social Science; Delegate from the United States to the International Congress for the Prevention of Syphilis and the Venereal Diseases, held at Brussels, Belgium, September 5, 1899, etc. Illustrated with 233 Engravings, 6½ x 9¾ inches. Pages xvi–1024. Extra Cloth, $5.00 net. Sheep or Half-russia, $5.75 net. The F. A. Davis Co., Publishers, 1914-16 Cherry Street, Philadelphia.

The publication of Dr. Lydston's book will in all probability be received with more than ordinary interest, for the reason that the writings of the distinguished author have always been read with great appreciation by those of the Medical and Surgical profession who have made Genito-Urinary and Venereal Diseases their special study. This being the case, we agree with the author when he states in the preface that the issuance of the work at this time "hardly requires either apology or explanation." The writer is so frank in his style that the volume makes exceedingly pleasant reading without in the least wearying the peruser. From a passage in the very brief preface we would infer that the author, in treating of the various subjects embraced in the volume, had not always confined himself to the "beaten pathway" followed by his predecessors, as he says: "I have embraced the opportunity herein afforded me for airing a few heresies of my own." Every topic of importance that has any connection with the subject is given as much space as its importance warrants. The first chapter deals with "Genito-Urinary and Sexual Hygiene" and the second with "Urinalysis in its Surgical Relations," and the chapter on "Gonorrhœa (in the male) occupies 47 pages. The important subject of stricture is very ably dealt with, and takes up 93 pages. Space will not allow of our referring to other chapters which are equally interesting and valuable. To those of the profession who know Dr. Lydston as a practical surgeon and writer, it is unnecessary to commend the work. His name is a sufficient guarantee to the profession. The print and binding are up to the usual standard of the publishers, while the numerous illustrations are admirably executed. The general index, which is elaborate and comprehensive, is placed at the end of the book. The work is admirably adapted to the uses of the general practitioner, and we can strongly recommend it to the profession.

R. C.

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**A Text-Book of Materia Medica, Therapeutics and Pharmacology.** By George Frank Butler, Ph.G., M.D., Professor of Materia Medica and Clinical Medicine in the College of Physicians and Surgeons, University of Illinois. J. A. Carveth & Co., Toronto, Canadian Agents. Cloth, $4.00; sheep or half morocco, $5.00, net. Third Edition, thoroughly revised.

The rapid changes which have taken place within the last few years in the Armamentaria of the medical profession requires frequent revision of works of this class. When this work first made its appearance three years ago, its arrangement was made on a new basis. It embodied the synthetic classification of drugs based upon therapeutic affinities, believed by the author to be the most philosophical and rational, as well as that best calculated to engage the interest of those to whom the study of the subject is wont to offer no little perplexity. This arrangement would seem to have been well received, for within a very limited time two editions have been exhausted. We are not surprised at this—for, having examined the work very carefully, it commends itself to our judgment as being an excellent Text-Book for the class room, and equally good as a standard volume for the book-shelf of the practising physician. We find the pharmacological section very complete, exceptionally lucid. Much of the rubbish with which the drug market is flooded is, we are glad to say, not noticed, and only such of them as have proved of unquestionable value are be found within its pages. "Untoward Action" and "Poisoning" are treated under separate heads. By the former it is intended to record the effect of medicinal doses in developing certain symptoms dependent more or less upon idiosyncrasy, but not necessarily assuming the aggravated form incident to toxic doses. Comparing the first with the present edition, we find that an immense amount of labor has been expended upon it, with the result of placing the work in every way up to date and well deserving of the support of the profession.

F. W. C.

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# PUBLISHERS DEPARTMENT.

We learn with pleasure that Messrs. Wm. R. Warner & Co. have received a silver medal and diploma, the highest award at the late National Exposition, held in Philadelphia. It will also no doubt prove very gratifying to their many patrons to know they are prescribing remedies of such recognized therapeutic superiority.

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CANADA
# MEDICAL RECORD

FEBRUARY, 1900

## Original Communications.

### THE REFLEX SYMPTOMS OF RETROVERSION OF THE UTERUS.

By A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., Eng.
Fellow of the British and American Gynecological Societies; Gynecologist to the Montreal Dispensary; Surgeon-in-Chief of the Samaritan Free Hospital for Women; Surgeon to the Western Hospital; Professor of Clinical Gynecology in Bishop's University; Consulting Gynecologist to the Women's Hospital, Montreal.

Although I have operated upon and, with a few exceptions, cured one hundred and thirty-five cases of retroversion with adhesions by performing ventrofixation, and eighty cases of retroversion without adhesions by Alexander's operation of shortening the round ligaments, I am not yet satisfied, for I am convinced that there are yet several hundreds of women in this province alone who are suffering from this disease with its numerous symptoms. These women could be cured almost without risk by one or the other of these two operations. I say almost without risk, because when there are adhesions and the abdomen has to be opened, and perhaps a diseased ovary has to be removed, even then there is only a risk of about one per cent. While, if there are no adhesions and we can put up the uterus with the bi-manual manipulations or by means of the sound and hold it up by shortening the round ligaments, this operation has been so perfected that there is absolutely no danger at all. During the first years after it was introduced there were many hernias and sometimes a death.

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but these accidents are no longer to be feared in the hands of operators of experience and with our present rigorous asepsis.

In this short paper I propose only to call attention to the symptoms, and especially the more obscure ones, by which this condition can be recognized. We must suspect its presence, and then search for it by a vaginal, preferably a bi-manual examination, whenever a woman comes to us with the following symptoms:

1. Bladder troubles manifested by frequency of micturition caused by the pressure of the cervix against the neck of the bladder. When the fundus goes backwards the cervix, as a rule, points forwards.

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2. Troubles in the rectum, either pain during defecation or obstinate constipation even when the patient's bowels have been made liquid by means of purgatives, the uterus acting as a rubber valve, the more the woman bears down the tighter it closes. Sometimes there is dysentery or rectal tenesmus due to the pressure of the heavy fundus on the rectum which ends by ulcerating it; even when there is nothing in it the patient feels as if the bowel was full This is one of the obscure symptoms and must be searched for, as the woman will, as a rule, tell us that she is constipated, and it is only by questioning her that we will ascertain that her movements are liquid. When this condition of the stools is present, we will surely find either a stricture of the rectum or obstruction from the retroverted fundus.

3. Disorders of the brain and nervous system. The great sympathetic nerve, contrary to the cerebro-spinal system, has its brain at the lower end of the spine, just about the place where the retroverted fundus will lie upon it, so that with every movement the woman makes, the great sympathetic receives a blow or impression which is conveyed to the brain, causing headaches and neuralgias in other organs, the heart, lungs, liver, stomach and bowels. More than once I have had patients who vomited constantly until the cause was discovered in a retroverted uterus, the vomiting stopping at once on replacing the displaced organ.

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4. Disorders of intelligence. When the irritation has lasted a long time the nutrition of the brain suffers seriously, and the patient may even loose her reason. I can recall at least a dozen cases in which the women themselves told me that they were ashamed of themselves for being so disagreeable to their husbands; the kinder their husbands were to them the worse they treated them. Two months ago a lady came to me from British Columbia to consult me on account of nervous attacks. She did not know the cause of them, but she assured me that if I did not discover it, and cure her, her husband would leave her, so disagreeable towards him had she become. Her father assured me that she had formerly been of a sweet and gentle disposition, and that a great change had taken place in her since a few years. She presented such a pale and worried appearance that I at once suspected that she had a retroversion, and, on examining her, my suspicions proved to be well founded; there was a large and heavy uterus with the fundus lying in the hollow of the sacrum. A few days later the round ligaments were shortened, and, after three weeks, she assured me that she felt quite differently. Another woman, whose history lies before me as I write, stated that for nine months previously she had been having strange ideas; for instance, she had an almost irresistible impulse to throw herself out of her bedroom window; she was, therefore, afraid to go up to her room unless some one went with her. Also, when she had a knife in her hand there was a great temptation to drive it into her heart or to cut her throat with it, so that she had to throw it down and run away from it. I at once suspected a retroversion, looked for it and found it. As it was firmly fixed, I had to open the abdomen and do ventrofixation. The very next day on my visit to the hospital she expressed her gratitude, saying: "Whatever you did you have removed that cloud from my brain; my trouble has gone." On asking her if she had much pain from the operation, she replied that "That was of no account compared with the sadness which before had overpowered her."

5. Dyspareunia and sterility. Of the two hundred and

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fifteen women who were operated on for displacements, about three-quarters or about one hundred and fifty were married, and nearly all of these complained of pain on coitus. This is not surprising when we remember that the uterus is directly in the road of the male organ, and only about an inch or two from the vulva. Moreover, it is swollen and exceedingly tender, several patients having described their pain as being similar to the throbbing of a whitlow. When a woman is irritable and angry with every one, it is easy to understand that she will not be pleased with her husband for causing her such severe pain as coitus under these conditions implies. As for the sterility, about twenty babies have followed the eighty Alexander operations, but only two or three have followed the much larger number of ventrofixations, this being due to the fact that when there is fixation the tubes are always diseased. I did not think that the forwards or backward position of the cervix was of so much consequence to fecundation until I had seen pregnancy follow immediately, and without any other treatment, in women, who had been married many years without having children, after placing the cervix in its proper place. One young woman who had been having illicit intercourse during several years without any consequences because she had a retroversion began to suffer so much pain that her physician sent her to me for an Alexander. The operation succeeded so well that on her return to her lover she immediately became pregnant and had a normal delivery.

6. Symptoms due to the uterus, ovaries and tubes. Dysmenorrhœa and menorrhagia. Almost all these women suffered from dysmenorrhœa caused by the pronounced congestion of the genital organs. The blood is pumped into them by the arteries, but cannot get out by the veins because they are twisted and compressed. The endometrium becomes varicose and swollen, causing both a painful obstruction to the escape of the blood and a profuse flow. The ovaries become so inflamed that ovulation causes excruciating pain.

7. Miscarriages. When a woman has had several mis-

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carriages at the third month which are not due to syphilis, we will almost surely find on examining her that she has a retroversion. A few months ago I was called by Dr. Grant Stewart to a case of retention of urine due to retroversion of the pregnant uterus. She was suffering terribly, and a miscarriage would soon have come on; her physician tried to get the uterus up, but found it firmly wedged below the promontory of the sacrum. Although I placed her in the genu-pectoral position, it was only after a quarter of an hour's firm pressure with my finger that I was able to dislodge it from between the utero sacral ligaments. I need hardly add that all her symptoms disappeared the moment that the uterus was replaced. Another woman who was sent to me by Dr. King, of Compton, was pregnant about three months, and the fundus filled the pelvis, the uterus being bent on itself and the cervix being flattened against the symphisis pubis. It was impossible to get the fundus up without opening the abdomen, which I did, and then performed a ventro-fixation. She had a normal confinement, and the womb has not fallen since.

We used to think that it was a sort of moral rape to make a vaginal examination of an unmarried woman, but now we know that virgins suffer from displacements quite often, and that their suffering cannot be remedied without removing the cause. While writing these pages a single woman of thirty came to my office complaining of dysentery, for which she had consulted me three years ago, at which time I did not examine her, and as I did not do her any good she left me and passed through the care of several other physicians without any benefit. This time, however, she insisted that I would examine her, as she felt sure that her womb was the cause of her trouble. And she was right, for on making a vaginal examination I found it completely turned. To-morrow morning I have to operate on another girl who consulted me for dysmenorrhœa, which compels her to remain in bed one day every month, and her period lasts seven days, and is profuse. She was so tender that it was impossible for me to examine her without an anæsthetic.

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With one I ascertained that she had a retroversion, which was easily replaced with the sound. I intend to dilate, curette and shorten the round ligaments at one sitting.

In conclusion, I would advise every family physician to make an examination, either with or without an anæsthetic, so as to assure himself whether there is a retroversion of the uterus, not only in those cases in which the symptoms point directly to the uterus, but also when there are reflex symptoms which might possibly be due to this cause.

250 BISHOP ST., Montreal.

# Selected Article.

## THE DIFFERENTIAL DIAGNOSIS BETWEEN CHRONIC JOINT DISEASE AND TRAUMATIC NEUROSES.*

By REGINALD H. SAYRE, M. D., New York.

Those who have had extensive experience with disease of joints realize how difficult it is at times to decide whether or not a joint is involved when the symptoms of imflammation are ju-t beginning to make themselves manifest, and that frequently several examinations of the patient may be necessary before an exact diagnosis is arrived at. They also realize how frequently such cases are treated for rheumatism, growing pains and neuralgia for months before the deformity becomes so prominent as to force the true nature of the disease upon the observer. It is usually supposed, however, that, after deformity and disability have taken place, the picture is so marked as to make it impossible to fall into error, and that such cases need only to be seen in order to be recognized.

My experience, however, leads me to differ from this view, as I find certain cases in which there is no joint inflammation present, symptoms so nearly approaching those of arthritis that they have been treated by men of large experience as if the joints were involved. I believe these mistakes in diagnosis are usually caused by failure to get the complete history of the case in the first place, by too superficial examination in the second, the patient's clothing not being

* Read before the New York State Medical Association, October 26, 1899

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sufficiently removed to enable the physician to make a proper investigation; and, third, by a lack of attention to minor symptoms which, properly interpreted, would prevent the observer from reaching an erroneous conclusion.

Many cases of injury are followed by pains and disorders of the nervous system, and this not only in instances when the injury has been caused by a railroad accident, or been received in consequence of the carelessness of some person who can be held responsible for the damage, but when the patient alone is to blame and the possibility of legal redress does not enter into the question. That a traumatic neuritis is set up in these cases there can be no doubt, and the variety of neurotic complications that may follow such an injury is most surprising. At times also there are neurotic disturbances, the result of misplacement of the viscera, which may be classed as traumatic neuroses, though the trauma is merely that of abnormal pressure on a nerve or an abnormal stretching of its fibres.

In many of these cases, among symptoms that are present are pain in the neighborhood of a joint, accompanied by a limitation of motion in the joint, and more or less marked deformity, the physician being called upon to determine the nature of the disturbance which has given rise to these symptoms.

Has the patient Pott's disease or not? Has there been a fracture of the vertebra, or is tuberculosis or malignant disease of the spine present, or is the difficulty simply a neuritis set up by a traumatism and aggravated perhaps by inherited tendencies, a rheumatic diathesis, or an exhausted state of the nervous system? Are the atrophy and disability and distortion of a limb the result of hip disease or not? Does a patient require rest and protection for the joint, or should vigorous exercise be prescribed? These problems are extremely difficult to answer, and in many instances can be answered correctly only by the most careful and thorough examination of the patient's previous and present condition, taking into account the history of the case and noting on more than one occasion the attitude of the patient, the location of the pain, the presence or absence of muscular spasm, the range of temperature for several days and at different times in the day, the presence of motor or sensory disturbances in other parts of the body, and finally by taking careful note of the patient's mental condition.

One of the distinguishing points between a nerve inflammation and an inflamed joint is the rapidity with which

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symptoms of an injury to a nerve follow the trauma which produced it, while it may be months after the injury that manifestations of joint inflammation are marked enough to attract attention. While atrophy is a prominent and constant symptom in chronic inflammation of the joint, and makes its appearance usually before pain is at all pronounced in its character, yet it does not follow the onset of a marked traumatism so speedily as in the case of injury to a nerve.

Another of the most important factors in discriminating between a traumatic neurosis and a chronic inflammation of a joint is the subnormal temperature that is usually present in the former, just as it is in various diseases accompanied by marked depression of the vital forces. There seems to be a lowering in tone throughout the entire system, with a corresponding decrease in the body heat. In chronic inflammation of a joint, however, there is usually a slight increase in temperature, say to 99° F., and one of the best guides to the activity of the destructive process going on in the bone is found in the reading of the thermometer. The local temperature also is apt to be much depressed after an injury to the nerve supplying this part, and at times an extremity or a part of an extremity will show a lowering in the surface temperature of one or two degrees below that of its fellow, or of other parts of the body. On the contrary, if an inflamed joint be at all near the surface, the increase in its temperature is usually sufficient to be detected by the touch, should a surface thermometer not be at hand. I would draw attention here to the fact that we may have a lowering of surface temperature in an extremity which has been kept at rest for a long time, either in bed or in a splint, while a joint in this extremity, as the knee or ankle, for instance, shows a marked increase of heat, and this distinction must be kept in mind in making a diagnosis between these cases and those of local subnormal temperature due to nerve involvement.

One of the early, probably the very first, symptoms of an inflamed joint is involuntary spasm of the muscles controlling that joint, and, as the disease goes on, this spasm becomes more and more pronounced. One of the peculiarities of this spasm is that passive motion within a certain limited range may often be made with entire absence of pain or resistance, while efforts at voluntary motion on the part of a patient, or motion greater in extent than that which the severity of the inflammation permits, at once excites muscular spasm and gives the appearance of complete ankylosis. Nature does not oppose motion of a joint so long as that motion fails to

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inflict injury, but as soon as it begins to cause irritation the muscles that control the joint at once spring into action in their effort to relieve and prevent the pain which is caused by the motion. If an anæsthetic is given in such a case the sensibility of the nerves is destroyed, and the muscles in consequence fail to control the movements of the joint, because they are no longer stimulated, and the physician is hereby deprived of the very symptom which would have been of vital importance to him had he made use of it intelligently. In many so-called "hysterical joints," and in these neurotic cases of which I speak, there may be a simulation of ankylosis and of muscular spasm, but careful observation will usually enable the physician to distinguish this from the true spasm of joint disease. By engaging the attention of the patient in other things and noticing the position of the joints meanwhile, motions will often be observed in joints supposed to be ankylosed. At times the patient may be induced to move the joint by placing the body in a different position from that in which the movement has usually been attempted, and then attempting to secure motion of some other joint, the movement of which will act on the joint under examination, the patient meanwhile having the attention concentrated on efforts to move the other joint, about which there is no question as to the diagnosis.

In cases of joint injury the location of the pain is to be borne in mind, and it may be a help toward excluding joint disease if the patient locates the pain in different places at different times, and at points other than those where the nerves supplying the affected joint should come to the surface. In spinal cases a tenderness along the whole length of the spinal column is almost proof in itself that the case is neurotic and not ostitic, the pain of bone inflammation being almost always confined to the distal extremities of the spinal nerves; or, if the pain is felt in the back, it is only in a limited area. Should the patient be awakened at night, especially just as he is dozing off to sleep, by sharp pains that cause a loud, sudden cry, it is almost certain that inflammation of bone is present. The general appearance of the patient will often aid greatly in eliminating bone inflammation. The expression of certain neurotics can hardly be described, but, their appearance once recognized, the picture is as typical as the expression of melancholia or mania.

In some neurotic cases there will be found a peculiar œdema of an extremity which, being associated with great

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tenderness, may give rise to the supposition that a bone abscess is present, but a distinction can generally be made by the observation that the pain is not so localized as in a bone abscess, and extends frequently along the course of some nerve, and may at times be accompanied by nodosities of this nerve, changes in the color of the skin, purple or blue spots which may be elevated, and at times by patches which are very painful.

From the numerous other cases that have come under my observation I would say that in taking a differential diagnosis between chronic joint disease and a traumatic neurosis, the following points were chiefly to be noted :

1. A neurosis is apt to follow injury sooner than is disease of a joint.

2. The temperature is usually subnormal in a neurosis and elevated in inflammation of a joint.

3. The local temperature is usually much lower in case of a neurosis than in disease of a joint.

4. Atrophy progresses more rapidly after injury to a nerve.

5. True muscular spasm is not present except in joint disease. It may be simulated, however.

6. True night cries are pathognomonic of joint disease.

7. The appearance of the patient, if indicating a disordered nervous system, may aid in the diagnosis.—*N. Y. Med. Rec.*

# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine University of Bishop's College; Physician Western Hospital.

### SORE THROATS.

There are some people who suffer from recurrent attacks of sore throat, tonsillitis and pharyngitis on the slightest exposure or imprudence throughout the winter season. The doctor is called in, prescribes tincture of iron, chlorate of potash, tincture of guaiac, salicylate of soda, etc., with a gargle, and soreness and swelling abate, the patient no longer needs to clear the throat every moment, but the

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structures do not return to a normal condition, some passive congestion remains, and soon another attack is precipitated. This liability to repeated attacks of sore throat is not altogether seasonal. Many persons entirely escape or are stricken, suffer acutely for a few days and rapidly recover, to hear no more of the malady. Frequent attacks of sore throat are due to disease of the blood. Morbific matter accumulates in the blood and makes a breach at a point favorable to rapid congestion and exudation. The throat furnishes just such a locality. Its tissues are normally very sensitive and easily congested.

The treatment of sore throat of the chronic and recurrent variety requires something more than the local use of gargles and remedies to allay feverishness and restore the secretions ; *prophylaxis* must be secured by the use of remedies to put the blood in a healthy condition. Its quality, volume and rate of circulation must be brought up to the standard of health. We believe that Ecthol will do this more satisfactorily than any other remedy. It increases the number, promotes the integrity and stimulates the movement of the red blood corpuscles, a vital factor in improving nutrition and circulation generally. Under its use the blood stream is accelerated in a normal manner, bathing and vivifying the tissues, yet preventing congestions.

Locally, Ecthol is used as a gargle either pure or in combination with Listerine, carbolic acid, hydrogen peroxide or other antiseptics, and has a very beneficial effect, checking any bleeding, reducing inflammation and hastening resolution.

Old sore throat cases are often very troublesome, the patients being neurotic, anemic and morbid generally, and we hope the profession will try this remedy, which has shown itself to be not only curative but *prophylactic* in aggravated cases of recurrent sore throat.—*Medical Brief.*

## TREATMENT TO INCREASE MAMMARY SECRETION.

From "Sajou's Annual and Analytical Cyclopedia of Practical Medicine," we quote as follows :—

"The bowels should be regulated by proper dieting and massage or exercise rather than by laxatives, and it is highly desirable that there should be at night uninterrupted sleep for six hours for mother and child. Galactagogues are valueless in the majority of cases, most of them exerting

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practically no influence upon the gland. Occasionally a slight stimulating effect may be noted, but this lasts only a short time, and the organ soon lapses into its former torpor. Beer, ale, porter, and other malt liquors, especially alcoholic beverages, are more hurtful than beneficial, and what improvement may show itself is due mainly to the confidence in the beverage taken, through the agency of auto-suggestion. The quantity of milk may be increased, but its quality is compromised, especially when poor beer is consumed by the mother. It encourages the production of fat at the expense of the casein or milk sugar. Pure malt may be substituted with great advantage.

## PNEUMONIA TREATED WITH ANTI-PNEUMONIC SERUM.

Fanoni (N. Y. Med. Jour., Vol. 70, No. 9) has studied the effects of Professor Pane's anti-pneumonic serum in six cases of pneumonia. The quantity of serum used in these cases was from a minimum of 20 cubic centimeters to a maximum of 120 cubic centimeters. In some of them only the serum No. 1 was used, in others only the No. 2, while in still others both strengths were used. The resolution in these cases was as follows :

First case, eighth day, by lysis ; second case, sixth day, by lysis ; third case, tenth day, by lysis ; fourth case, seventh day, by crisis ; fifth case, seventh day, by lysis ; sixth case, sixth day, by lysis.

From his own experience, and that of his confrères in Italy, the author draws the following conclusions :

1. That Pane's anti-pneumonic serum is the rational remedy in pneumonia, as it constitutes the specific treatment, the same as Behring's antitoxin does in diphtheria.

2. That injections with this serum are not painful, are simple to administer, and do not produce any general or local reaction.

3. That serum over five months old is no longer active and produces no results, although it does no harm ; and, after it is four months old, it begins to lose strength, and the amount given after this time should be increased in proportion as the date of the preparation of the remedy is removed from the date of administering up to the fifth month.

4. That the serum will not do harm, even if given in doses of 100 to 150 cubic centimeters in twenty-four hours.

5. That the serum in all these cases under my observation

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has shown wonderful efficacy, not only in producing rapid improvement of the general condition, but in hastening resolution in case it is given early in the disease.

6. That in any lobar pneumonia, especially if the prognosis is grave, it is the duty of the physician to use this serum, and if he fails to do so there is no excuse for such an act, except ignorance of the work that has been done in the field of the serum therapy of pneumonia.—*Memphis Medical Monthly.*

## THE TREATMENT OF SHOCK.

Experiental work upon the pathology of shock shows it to have as an essential element a paresis of the vaso-motor nervous system. The maintenance of vascular pressure by contracting the peripheral arterioles is the most efficient means of overcoming the condition. The efforts of surgeons have been largely addressed to the heart, as the symptoms seem to be referable to that organ. Experimental study shows that a heart that is only partially filled with blood beats rapidly and feebly. The physiologist teaches that the veins of the body are capable of containing the entire blood supply ; indeed, those of the abdominal region alone are said to have nearly sufficient capacity for this purpose, or, at least, they may contain a quantity which seriously impairs the integrity of the circulation. A marked fall in the peripheral resistance results in a rapid and correspondingly feeble heart's action. This is not to be met by stimulating the heart, as by such means we only aid in emptying the arterial system. The aim should be to use those remedies which caused a prompt contraction of the peripheral arterioles, and so restore the altered balance of the circulation.—*Medical Review.*

## THE CAUSE OF OLD AGE.

Prof. Mechnikoff, whose fame rests upon the Mechnikovian theory of phagocytosis, has recently come forward with a theory of old age, based upon the omni-important leucocyte. He states that there is a sort of social distinction among the leucocytes, some of these being common, or, as we might translate it, plebeian, while others are noble. The common cells are found in all the organs, and may be transformed at any time into connective tissue cells. The noble cells are those which may form part of the parenchyma of any of the organs. Old age is essentially a strife between these two forms, in which the common type, or connective

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tissue builders, gains the mastery ; and thus we have a replacing of normal tissues by connective tissue structures, or a sclerosis. The theory has an element of the picturesque, though as a practical working hypothesis it will probably not be of great value in overcoming the effects of age and of advancing sclerosis. Modern science appears to be looking for the fountain of youth with all the enthusiasm of Ponce de Leon. —*Medical Review.*

## DIAGNOSTIC AND THERAPEUTIC IMPORTANCE OF THE X-RAY IN MEDICINE AND SURGERY.

Among the diagnoses which may positively be made by the X-rays are : Early diagnosis of aneurysm of the aorta ; determination of the boundaries of the heart in emphysema ; determination of apparent and real hypertrophy of the heart. With the aid of the fluoroscope abnormal rhythm of the heart and the effects of drugs upon it can be carefully studied. The differential diagnosis between tumors of mediastinum and aneurysms of the aorta can absolutely be made. Aneurysms of the various arteries and the calcification of these various arteries can be made out. Respiratory tract : Tumors and foreign bodies in the larynx, Tumors, foreign bodies, gangrenous areas in the lungs, exudate into the pleural cavity, thickness of the pleura and pneumothorax are all distinctly to be made out. Gastro-intestinal tract : Foreign bodies in the esophagus, stomach and bowel can be detected, and the differential diagnosis between the tumors and diverticula of the esophagus made. Furthermore, abnormalities in the shape and position of the stomach can be made out by means of inflation, or the introduction of sounds and bismuth. Tumors of the omentum, the bowel, the pancreas and the liver have been made out. Urinary apparatus : Stone in the bladder and the kidney and tumor of the kidney. Head : Fractures of the skull, splinters of bone and tumors in the brain, foreign bodies in the eye and in the nose, empyema of the frontal sinuses and of the antrum of Highmore. The importance of the X-ray in purely surgical cases needs no explanation here. Therapeutically, the author has good reports of the effect of the X-ray in cases of neuralgia of the facial, occipital and intercostal nerves. In some cases joint and muscle rheumatism were favorably influenced ; in others they were not. In the treatment of certain affections of the skin, notably lupus, eczema and psoriasis, excellent

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results have been obtained. The depilatory action of the X-ray has found a use in cosmetic medicine. The therapeutic effect of the X-ray in pulmonary tuberculosis has up to the present time been nil. All in all, the X-ray has to be considered rather as an aid to diagnosis than as a therapeutic agent of the first rank.—*Medical Review.*

## HYDROTHERAPY IN THE PREVENTION AND CURE OF PULMONARY TUBERCULOSIS.

In Knopf's recent work, "The Prophylaxis and Treatment of Pulmonary Tuberculosis," the author calls attention to the value of hydrotherapeutic measures in the prevention and cure of pulmonary tuberculosis. He especially emphasizes the value of using cold water externally. The manner of application as suggested by the author is to precede the application several days by a dry massage of the skin, followed by inunction. Following this, friction with pure alcohol is recommended; then half alcohol, half water, and, lastly, friction with water alone. This is then followed by the cold sponge bath, the affusion, and last the douche. It is essential to follow this treatment with vigorous friction, so that a good reaction will take place; otherwise the treatment will do more harm than good.

The value of the cold morning bath for both old and young is inestimable. Its universal application in conjunction with a correct dietary and a moderate amount of systematic exercise would do much toward the eradication of the tendency to disease, and also to the cure of many diseases in their incipient and chronic stages. This form of treatment was known and systematically practiced by many of the ancients, with the result that they were a vigorous and energetic people.

The cold sponge or friction bath is a most efficient measure for energizing the circulatory processes and establishing a permanent healthy circulation in the skin and other excretory organs. The elastic step and buoyant air exhibited by one who has reacted properly to his morning bath is evidence that there is great energizing power in cold water. Great care must be exercised, however, in the use of this excellent remedy in the treatment of the very young; and in feeble and aged individuals, for upon their power to react depends the value of the application. For those who react poorly, a good way is to see that the room in which the application is to be made is warm and free from draughts

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of air; the patient should also be warm and comfortable before beginning the treatment, otherwise reaction will not take place.

In the cases just referred to, the cold friction sponge is an excellent means of obtaining a good reaction. The attendant should be equipped with a mitt made of some rough material which, when rubbed over the skin, will produce considerable friction. The mitt is dipped in cold water and rubbed vigorously over a small area of the skin until a good reaction results; the part is then dried by means of a Turkish towel, and immediately covered. Other parts of the body are then treated until the whole surface of the body has been gone over. A feeble person can stand the water much colder when this form of treatment is employed than when ordinary hand friction is used. The friction dilates the peripheral vessels, allowing more blood to flow through the skin, thus causing a feeling of warmth in the part, while at the same time the sensory nerves are being stimulated by the cold water.

Many diseases other than tuberculosis can be prevented and cured by means of the simple, inexpensive and universal remedy. Every physician should instruct his patients how to fight for health; for a vigorous warfare must be waged against the almost countless foes which are lurking on every hand, seeking a favorable opportunity to pounce upon us, and in many instances make us victims of some lingering disease.—*Modern Medicine.*

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# SURGERY.

IN CHARGE OF

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## CELLULOID SUTURES AND LIGATURES.

Pagenstecher (*Deut. Med. Wcch.*) takes a good thread, boils for half an hour in a 1 per cent. solution of soda, washes in boiling water and dries between sterile compresses. It is then soaked in a solution of celluloid and passed again through the same solution. Afterward it is sterilized by

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steam under pressure and preserved for use either dry or in an alcoholic solution of bichloride of mercury. The threads have a smooth surface, never tangle, cannot absorb secretions, and are easily tied. Pagenstecher uses these celluloid threads to the exclusion of silk, and the use of catgut for ligatures has been greatly reduced. The results have been good and the saving considerable.—*Buffalo Medical Journal.*

## THE DIAGNOSIS OF JOINT TUBERCULOSIS.

The writer found that nearly 31 per cent. of all joint diseases applying at a dispensary for special orthopedic diseases were cases of joint tuberculosis.

One of the most important things in the successful treatment of tuberculosis of joints is an early diagnosis.

That heredity plays in many an important part is true. Frequently children are affected by a tuberculous disease of the joint from a tuberculous father, the mother apparently in good health or having slight anæmia. Rheumatism of the joint, particularly in young children, is the most frequent condition with which this disease is confused. Rheumatism of a single joint is an exceedingly rare disease, especially in children. Most of such cases when followed carefully are found later in the hands of specialists being treated as tuberculous. The symptoms upon which the diagnosis mostly depends in joint tuberculosis are spasms and atrophy. The spasm of the muscles is tetanic in character, and occurs very early in disease. This is followed soon by wasting of the muscles; no matter what joint is affected with tuberculosis, these two symptoms are always present. In the spine, particularly in the lumbar region, it is one of the earliest symptoms, often before the occurrence of deformity, spasm of the psoas and iliacus may be detected. In hip disease the adductors are among the first, and in the knee joint the ham string tendons are frequently contracted at a very early stage. The use of Roentgen ray is of use only in advanced tuberculosis. The appearance of the cartilages and bones being irregular and roughened very differently from the clear and distinct outline of photographs in cases of chronic synovitis. In specific arthritis, by means of the X-ray, the deposits of fibrous tissue may sometimes be detected. These will obscure the normal outline of the joint, but there will not be the roughened, irregular and worm-eaten appearance of tuberculous disease. A picture should also be taken of the sound joint on the opposite side in the same position as the

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diseased joint for comparison. Examination of the blood, in cases of suspected tuberculosis of the joint, is of assistance, as marked anæmia or leucocytosis is frequently a forerunner of a tuberculous outbreak in a joint. The differential diagnosis of tuberculous disease of the joint is so important that the author tabulates the points of differentiation between non-tubercular chronic synovitis, tubercular chronic articular arthritis and specific syphilitic arthritis.

NON-TUBERCULAR CHRONIC SYNOVITIS.

1. Marked effusion, capsule thickened. 2. Joint outline enlarged and obliterated. 3. Motion nearly normal. 4. Reflex muscular spasm absent. 5. No atrophy. 6. Pain absent. 7. Night cries absent.

TUBERBULAR CHRONIC ARTICULAR ARTHRITIS.

1. No fluctuation, capsule not thickened. 2. Joint outline distinct and clear. 3. Motion limited. 4. Reflex muscular spasm present. 5. Marked atrophy. 6. Night cries present.

SPECIFIC SYPHILITIC ARTHRITIS.

1. Slight effusion, capsule thickened. 2. Joint outline distinct, enlarged. 5. Atrophy slight. 6. Pain moderate upon motion. 7. Night cries absent.—*Dr. Jas. R. Young, Jour. of Tuberculosis; St. Paul Med. Jour.*

## BIERS' TREATMENT OF EARLY JOINT TUBERCULOSIS.

Biers' method of treating early joint tuberculosis is attracting considerable notice, and is worthy the attention of the general practitioner because of results claimed and because of its simplicity. The treatment consists simply in ligating the member above the affected joint with an elastic bandage of medium width. This is applied several times a day for a period varying from ten minutes to one hour, the bandage being only sufficiently tight to impede the venous circulation. The curative principle of the method seems to be in the fact that the locally increased carbonic acid gas and an increased phagocytosis attacks the micro-organisms. The results of this treatment have been so prompt and so universally good in tuberculous joint disease, and so decidedly negative in joint disease due to other causes, that it is considered to be of great value for diagnostic purposes. It is said that if considerable relief is not given after two or three applications, it may be assumed that the joint is not tuberculous.—*Memphis Medical Monthly.*

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## THE TOBACCO-POUCH SUTURE.

Doyen has lately been extending the application of the pucker string suture to abdominal surgery, using it on the appendix, intestine, stomach and Douglas' sac after abdominal hysterectomy, and now Quervain, after extensive tests on the cadaver, announces that it is stronger than the Lembert suture, and is peculiarly adapted to the peritoneum, when the latter is movable and the opening is of moderate size. The ends can be tucked in and the thread drawn tight like an anus, or the edges can be left out and the stitches taken with longer stretches on the outside, which forms a particularly strong and effectual method of suturing organs invested externally with serosa, such as the intestines and gall-bladder. He is confident that one trial will convince all of the remarkable advantages to be gained from this suture on the peritoneum.—*Journal American Medical Association.*

## STERILIZATION OF THE SKIN.

Senger (*Archiv. fur. klin. Chir.*, vol. 59, p. 425) gives the results of a long series of experiments conducted by him in order to discover the best method of sterilizing the skin. He finally adopted the following technic: (1) Mechanical cleansing of the skin with ordinary soap and water just as hot as it can be borne—about 40° to 45° C. (104° to 113° F.). This scrubbing should last at least five minutes. (2) Bathing or rubbing the hands with alcohol (40 to 60 per cent.). (3) Washing the skin for two minutes with a warm 2 to 5 per cent. solution of hydrochloric acid. (4) Washing the skin for one minute with a warm ½ per cent. solution of permanganate of potash. (5) Washing the skin with sulphurous acid until it is decolorized. The whole process takes about ten minutes. Senger insists upon having the solutions warm, claiming that their antiseptic action is much increased by the heat. By this method he has been able to obtain sterility in almost every instance in which the skin was tested by scraping. He objects to this method of making the test, however, on the ground that it is not as accurate as when small snips of the skin are imbedded in the culture material. When tested in this way the skin was found to be sterile in about 75 per cent. of the recent experiments. This is far in advance of the results he was able to obtain by any other method.—*Medical News, Nashville Jour. of Med. and Surg.*

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## THE BEST METHOD OF INTESTINAL ANASTOMOSIS.

J. H. Barbat, in the *Journal of the American Medical Association* of July 15, 1899, gives an experimental study of the results of different methods of intestinal anastomosis made in dogs. Circular interorrhaphy, he thinks, should always be the operation of election in restoring the continuity of the intestine, as it is the only method which restores the bowel to its natural condition, and it is the operation which should always be selected when no contraindication exists. His experimental work shows it is possible to make a safe and satisfactory end-to-end anastomosis. With practice a surgeon can, with nothing but a needle and thread, sew a divided bowel together and obtain a result which will almost equal that obtained by the use of the Murphy button. The button is superior to any suture method yet devised. The Murphy button and Frank coupler give the same anatomic result, but the button is safer than the coupler. Contraction following end-to-end anastomosis is usually due to faulty technique. A perfect Murphy button, properly introduced, is the quickest, safest and most reliable means of uniting the severed intestine.—*Medicine.*

## A NEW RECTAL DRESSING.

J. R. Remington, in the *Chicago Medical Recorder* for July, 1899, speaks of the necessity of careful attention to the dressing and after-treatment in surgery of the rectum. Much of the pain and swelling which follow the application of a ligature or the cautery can be prevented by the use of properly constructed rectal tampons. If these are made of simple gauze or cotton, the pain attending their removal is considerable, the tender granulations are broken off, and there is considerable hemorrhage. They retard the healing and favor the absorption of septic material. The tampon devised by the writer consists of a central rubber tube three-fourths of an inch in diameter and four and one-half inches long. Covering and attached to this are layers of gauze and cotton sufficient to furnish a tampon of the desired size. The whole is then covered by sterilized sheet rubber. The advantages which he claims for such a tampon are that there is no pain on its removal, and that it leaves the wound in a condition which makes defecation practically painless.—*Medicine.*

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## CURLED HORSEHAIR IN PLACE OF A SCRUBBING-BRUSH.

W. S. Forbes, in the *Pennsylvania Medical Journal* for July, 1899, says that ordinary curled hair forms one of the best mechanical devices for cleansing the skin that has yet been discovered. In its preparation about three drachms of curled hair is employed, and this is easily shaped by the hands into a loose pad about the size of the hand. When desired, the flattened mass may be held together by stitching with sterilized silk, catgut or other aseptic material, but this is optional, When once fashioned, it will hold its shape without change. It cannot cut or tear the skin, and it is easily cleansed with boiling water before and after each surgical operation. A solution of bichloride of mercury, 1 to 100, and steam to 100° do not act upon it. It may be kept in alcohol after being sterilized, and is thus always ready for use. It is cheap and efficient, and is far superior to the scrubbing-brush of tainted memory.—*Medicine.*

## CHRONIC ULCER OF THE LEG.

I have laid down this rule : An ulcer situated above the middle of the leg is syphilitic, regardless of history. I make it a rule to examine the heart, lungs and kidneys in all cases, as disease of any of these organs interferes with the local treatment. For instance, if the heart is diseased, passive congestion and œdema of the lower extremities are of frequent occurrence. Proper attention, then, to this organ, when compensation is possible, will greatly facilitate getting rid of the ulcer. But simplicity, cleanliness and the proper time to interfere are the sheet anchors in all cases. But, as to drugs, I have as yet to find one which will equal pure carbolic acid.—JOHN B. CORSIGLIA, *New York Medical Journal, N. Y. Med. Rec.*

## SURGICAL HINTS.

EXAMINE the urine in all cases of pruritus, eczema, gangrenous lesions, furuncles and anthrax. A certain proportion will show the existence of diabetes.—REMEMBER how frequently constipation aggravates prostatic obstruction. Some prostatic cases are immensely benefited by careful attention to this important detail.—IN APPENDICITIS, when the pain keeps on increasing, the pulse remains rapid, and the temperature remains high, delay in operating will soon be con-

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sidered, and very justly so, as amounting to malpractice.—SLIGHT RISES OF TEMPERATURE after an operation, even in cases which give no septic results, warn the surgeon that he is probably erring in some way, and that his methods and material should be pretty thoroughly overhauled.—MAKE A HABIT OF washing your hands in vinegar or dilute acetic acid before touching septic cases. Slight cuts and abrasions, whose presence was not suspected, are thus revealed, and you may better protect yourself.—IN DISLOCATION OF ONE SIDE of the jaw the chin is deflected away from the dislocated side. In bi-lateral dislocation the chin is advanced forward. In the former the face is distorted, while in the latter there is a peculiar expression of fear and distress.—IT IS SOMETIMES VERY DIFFICULT to remove foreign bodies broken off under the finger-nails. The best way is to apply carefully a ten per cent. solution of caustic potash and scrape away the softened portion. This is repeated until the foreign body is exposed.—SEVENTY-FIVE GRAINS OF PICRIC ACID dissolved in two ounces of alcohol, to which a quart of water is added, makes an excellent application for burns. There is nothing which deadens the pain better. It should not be used after granulation begins to take place.—AFTER A BLOW UPON THE HEAD, the hardened margin of a blood extravasation is sometimes mistaken for a protruding edge of fractured bone. If in doubt, press gently upon the spot steadily and continuously. If it is an extravasation it will gradually become pitted by the pressure.—A STARCH BANDAGE will not set so fast as a plaster one, but except for this it will do everything that may be done with the latter. Wet your bandage slightly before applying it, and then spread the starch paste over every layer. It has the great advantage that the materials for it are found in every house.—IF YOU EXPECT to use a thermo-cautery during an operation, see that your assistant wraps the handle in a sterilized towel before handing in to you.—DON'T SPEND half an hour in carefully sterilizing your hands, and then wipe them on any old towel that is lying around. Work with wet hands if you can't obtain a sterile towel.—AN ENLARGED PROSTATE often projects, as it were, into the bladder, thus increasing the length of the urethral canal. Hence an instrument must often be introduced farther than usual in order to reach the urine.—LOOK AT THE FOOT when a patient complains of enlargement of the femoral lymphatics. A suppurating ingrowing toe-nail or any other septic condition of the toe or foot is probably at

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fault. If this is properly attended to the glands will soon subside.—LARGE GLANDS in the neck of adults or old people are very apt to signify that a malignant process is taking place in the neighborhood; hence it is always well to examine the mouth, the tongue, the nose, and the throat carefully in such cases.—IN GENERAL OPERATIVE work, it is always useful to have two kinds of artery forceps, pointed and blunt-jawed. The pointed artery forceps are most useful for vessels in and near the skin, as they crush less tissue. The blunt-jawed forceps permits more rapid and efficient hæmostasis in the deeper tissues.—IN THE TREATMENT OF FRACTURES of the long bones, it is practically impossible to bring the broken surfaces end to end in perfect approximation. Our object is simply to accomplish this as nearly as possible, and in the lower limbs to secure such extension as will result in a bone of normal length.—AFTER AMPUTATIONS never wait to apply an artificial limb beyond the time when the stump is well healed and the patient is strong again. Disuse of the stump for too long a time makes it less able to stand the artificial limb. The only exception to this rule is when the operation was done for malignant disease, where early pressure and concussion might favor a return.—IN INJURIES OF THE SKULL requiring operation, it is well to remember that the prognosis depends a good deal upon the region involved. Thus in a series of over eight hundred cases it was found that the mortality was one to sixty when the anterior brain was affected, whereas it was one to thirteen in injuries of the central and posterior regions, and one to four and a half in those situated at the base.—*Internat. Jour. of Surg., N. Y. Med. Rec.*

## INJURIES TO THE BRACHIAL PLEXUS AND ITS BRANCHES IN DISLOCATIONS OF THE SHOULDER.

In injuries of the shoulder a guarded prognosis should always be made, unless the surgeon is quite confident that nerve injury can be excluded. It is by no means infrequent for a surgeon to be called to the dislocation of a shoulder that may or may not be complicated by fracture. The diagnosis is easily and quickly made, the bone is replaced in its socket, and a retentive apparatus applied, and the patient is informed that the outcome will be favorable. When the bandages are finally removed, it is found that the arm is quite helpless, or even if there remains good motion in the

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fingers and fair strength in the grasp, that the elbow cannot be carried from the side and the motion at the shoulder-joint is very limited. On examination the shoulder is found to be very much flattened ; sometimes a considerable groove is noted between the acromion process and the head of the humerus. The result from an operative standpoint is good ; the head of the humerus is found in the glenoid cavity, but the usefulness and range of motion of the arm is very greatly impaired. From the patient's standpoint the results are anything but satisfactory, and far from what he was led to expect when the probable consequences of the injury were first explained to him.

These untoward results are due to injuries of one or more cords of the brachial plexus or to some of its branches. The injury may have been caused by the displaced bone, or by the violence of the original injury, or to a combination of both of these. If the injury is to the brachial plexus or some of its cords, there may be paralysis of a considerable portion, or even all, of the muscles of the arm. There may be contusion with a restoration of function in a comparatively short time, or such contusion may be followed by a more or less extensive traumatic neuritis. This early paralysis from contusion may be overlooked in the pain and swelling incident to the original injury. If the neuritis and a paralysis involved the whole or a single trunk of the plexus, it is usually not difficult of recognition. The safest prognostic guide in these cases is sensation ; if it is absent and returns early, usually an ultimately favorable prognosis can be given, but this should be guarded by the statement that weeks or months may elapse before there is a restoration of motion in the paralyzed muscles. This is due to the fact that contusion is followed by neuritis, which results in a degeneration of the nerve. In simple traumatic cases we may generally look for a regeneration in the course of time, which will be aided by massage and electricity. In only a few of these cases is the paralysis permanent.

The most insidious and difficult of diagnosis is injury to the circumflex nerve, which is the one most frequently involved in simple dislocations. This nerve is a branch of the posterior cord of the brachial plexus. It passes through the quadrilateral space, bounded by the teres major, under head of triceps and subscapularis muscles, and by the surgical head of the humerus, where it divides into a smaller anterior and larger posterior division. It supplies the teres minor and deltoid muscles, and is the nerve of sensation for

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the skin covering that muscle. It sends an articular branch to the joint, which is the pathway of trophic influence. An injury to this nerve means a serious impairment to the use of the joint. The traumatism which has dislocated the joint has resulted in a chronic synovitis, and more or less pathological disturbance in the joint. At this time, to have its trophic nerve supply cut off is an additional misfortune, and one which frequently leads to chronic inflammation. Adhesions form, and with the atrophy of the deltoid muscle which accompanies the adhesions there is marked impairment of the movements of the shoulder.

To determine injury to the circumflex, it is necessary to carefully examine the sensibility of the skin over the deltoid. If tactile sensation is impaired over this region, a guarded prognosis should be made, as months must elapse before the nerve regenerates. The adhesions and joint troubles which follow injuries to this nerve are persistent and aggravated to a degree unknown in simple contusion or dislocation of the joint without nerve injury. We would lay especial emphasis upon this matter, as not infrequently malpractice suits following shoulder injuries are brought because the patient is led to believe that the outcome of the injury would be much more favorable than proved to be the case. —*Medicine.*

## GUAIACOL AS A LOCAL ANESTHETIC.

Guaiacol is being used extensively, especially in England, as a local anesthetic in operations upon the nose, throat and ear. It is said to be quite as efficient and to be much less dangerous than cocain. There is no hyperemia following its use, but its action is slow; it causes considerable smarting, and its odor is disagreeable.—*Medical Review.*

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# Therapeutic Notes.

℞ Dest fennel oil..... oj.
Chloral hydrate..... gr. xxxv.
Borax ..... gr. xv.

Wash the feet night and morning.

### Iodine in Treatment of Chronic Eczema of the Hands.

The *Revista de Medicina y Cirugia Practicas*, quoting the *Therapeutische Monatshefte*, attributes the following formula to Edlefsen :

℞ Iodine ..... gr. 1½
Potassium iodide..... gr. 4
Glycerine ..... gr. 180

M. Sig. To be applied every night, and the hands covered with compresses.—*New York Medical Journal.*

### Itch Ointment.

In a series of experiments at the St. Luke's Hospital, Paris, to determine what will cure itch in the shortest time, forty-one different preparations were employed. One of these, the following ointment cured in the smallest number of days :

℞ Sublimated sulphur..... ℥ ij
Subcarbonate of potash..... ℥ j
Adeps simplex..... ℥ viij

M. Sig. Apply morning and night.

The writer of this has been in the habit of adding to the above the oil of bergamont, three drams, thus adding to the flavor and potency of the ointment.—*Modern Medicine.*

In nephritis with scanty urine and high arterial tension, nitro-glycerine in doses of $\frac{1}{100}$ of a grain three or four times a day. It may be given either in solution or tablet triturates.

℞ Spiriti glonoini..... f. ℥ iv.

Sig. One drop in water three or four times a day, or

℞ Spiriti glonoini..... gtt i.
Sacchari lactis..... q. s.
Alcohol ..... q. s.
Misce et fiant tabellæ No. 1.

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Sig. One tablet three times a day.

In cases of nephritis with arterial relaxation, feeble heart, renal congestion, the following is valuable:

℞ Symphorolis (sodium sulfocafflate) ʒ iv.
Fiant tabellæ No. xxiv.

Sig. One tablet three times a day.

For the control of uterine hæmorrhage in threatened abortion the following is recommended:

℞ Hydrastinæ hydrochloratis..... gr. iv.
Pepsini saccharati..... ʒ i.
Misce et fiant chartulæ No. xvi.

Sig. One powder every two hours.

Among the most recent remedies recommended for asthma are suprarenal extract, orthoform and oxycamphor. Suprarenal extract is best given in five grain tablets, but is also useful in solution for application to engorged nasal mucous membrane.

℞ Extracti suprarenalæ hæsmostatici ʒ i.
Aquæ destillatæ..... f. ii.

M. Sig. Instill a few drops into each nostril several times a day.

℞ Orthoform ..... ʒ ii.
Fiant in chartulæ No. xii.

M. Sig. One powder used by insufflation twice daily.

℞ Oxycamphoræ (50 per cent. sol.) f. ʒ iv.
Elixiris aromatici..... f. ℥ iii.

M. Sig. A teaspoonful in a wine glass of water twice or thrice daily.

In pyogenic inflation of the bladder the internal administration of urotropin is now considered our most efficient remedy. It is particularly useful in cases with prostatic enlargement and inflammation.

℞ Urotropin..... ..... ʒ iv.
Fiant cachetæ No. xxiv.

M. Sig. One cachet three times a day, two hours after meals.

For irrigations of a chronically inflamed bladder and prostate, potassium permanganate against colon bacilli;

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corrosive sublimate against the staphylococcus, streptococcus and tubercle bacillus. Copper sulphate against the gonococcus. Silver nitrate against all, except the tubercle bacillus. The following is about the proper strength :

| | | |
|---|---|---|
| ℞ | Potassi permanganatis..... | gr. viii. |
| | Aquæ destillatæ ..... | O iv. |
| ℞ | Hydrargyri chloridi corrosivi..... | gr. iv. |
| | Aquæ destillatæ..... | O iv. |
| ℞ | Cupri sulphatis ..... | gr. viii. |
| | Aquæ destillatæ..... | O iv. |
| ℞ | Angenti nitratis..... | gr. xvi. |
| | Aquæ destillatæ. ..... | O iv. |

M. Sig. In using these, warm gently, and use by irrigation.

## Hay Fever.

| | | |
|---|---|---|
| ℞ | Acid (boric)..... | gr. xx. |
| | Menthol..... | gr. iv. |
| | Glyco-thymoline..... | ʒ ij. |
| | Sol. eucain B. 4 per cent., q. s. ad. | ʒ ij. |

Sig. Use in atomizer.

This treatment is to be used in the most obstinate cases where there is much irritation of the nasal mucous membrane.—Alexander Rixa.

## Varicose Ulcers.

| | | |
|---|---|---|
| ℞ | Zinc oxide..... | 20 parts. |
| | Gelatine..... | 80 parts. |
| | Glycerine..... | 20 parts. |
| | Water.....q. s. ad. | 200 parts. |

—Carl Beck.

## Diphtheria.

The local treatment is taken care of by means of a camel's hair brush dipped in the following:

| | | |
|---|---|---|
| ℞ | Hydrargyri bichloridi..... | gr. iss. |
| | Glycerini..... | ʒ vj. |
| | Hydrogen dioxid..... | ʒ ij. |

Sig. Use every hour or two, according to the severity of the case.—Dr. M. A. Albe, in *Cleveland Medical Gazette*, Vol. XIV., No. 3.

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### Diarrhœa of Typhoid Fever.

℞ Acidi sulphurici aromatici..... ʒ ij.
Ext. hamatoxylin. fld..... ʒ ss.
Spirit. camphoræ..... ʒ ss.
Syrupi zingiberis..... .....q. s. ad. ʒ iij.

M. Sig. Two teaspoonfuls when the stools exceed four in twenty-four hours.—Prof. Hare.

### To Relieve the Pain in Cystitis.

℞ Ext. hyocyami..... gr. j.
Camphoræ monobrom..... gr. ij.
Morphin sulphat..... gr. ss.
Cocoa butter..... q. s.

M. Et. ft. suppos. No. j.

### When Uræmia Threatens.

Use the hot pack over the kidneys, and give:

℞ Pilocarpine..... ..... gr. ss–j.
Hydrochloric acid dilute..... ʒ ij.
Aquæ dist..... .....q. s. ad. ʒ ij.

M. Sig. Teaspoonful every three hours.—N. A. Kremer, in *The Medical and Surgical Monitor*, Vol. II., No. 6.

### Croup.

The following prescription, suggested by Joseph Holt, of New Orleans, has been tried many times with the happiest results:

℞ Chloral..... gr. lxxv.
Potassii bromidi..... gr. xlv.
Ammonii bromidi..... gr. xxx.
Aquæ cinnamomi..... ʒ ij.

Sig. Teaspoonful, and repeat in twenty minutes if not relieved.

This is intended for a child about 7 years old. For younger children the dose is slightly diminished. The chloral relieves the spasm of the larynx, and the bromides allay the nervousness; so that the patient is soon asleep, and wakes the next morning as well as usual. The first dose generally gives relief. This prescription is of no benefit in true or membranous croup.—*Practitioner*, 1899, lxiii., 356.

### Threadworms.

☞ In the treatment of threadworms large injections must be used, and in view of the difficulty of dislodging the worms

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from the appendix, and their possible presence in the small intestine, the injection should be combined with the administration of drugs by the mouth. The vermiform appendix is a common habitat of oxyuris vermicularis in children.—STILL, *Medical Record.*

### URTICARIA.

Mr. Skinner, pharmacist to the Great Northern Hospital, recommends the following formula for allaying the itching burning sensation of urticaria :

| | | |
|---|---|---|
| ℞ | Liquoris hamamelidis..... | ʒ ii. |
| | Salis maris..... | ʒ ss. |
| | Aquæ destillatæ..... | O i. |

To be applied freely.

He also speaks highly of the following cold cream:

| | | |
|---|---|---|
| ℞ | Adipis benzoinat..... | ʒ iv. |
| | Ceræ albæ..... | ʒ ss. |
| | Cetacei ..... | ʒ i. |
| | Boracis ..... | ʒ ss. |
| | Glycerini ..... | ʒ i. |
| | Aquæ coloniensis..... | ʒ iiss. |

*Therapeutic Gazette.*

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# Jottings.

The best method for testing albumen in urine, and one which gets rid of the difficulties attending Heller's nitric acid test in the form of rings at the junction of acid and urine, is the follwing :

Place one drachm of strong colorless nitric acid in a test tube, then carefully allow about 1-2 drachm of distilled water to float on top of the acid by means of a pipette. The urine is now allowed to trickle through the layer of water, which washes it, and when it comes in contact with the acid a white film of coagulated albumen will be seen free from any coloring matters. This method is quite simple and free from error. In all cases when the urine is cloudy, it must be filtered before applying tests.

---

Dr. E. E. Clark, in an article in the *Med. Standard,* urges the importance of the general practitioner recognizing

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the gravity of middle ear suppuration. Many a child has, through early neglect, contracted a chronic suppuration of the ear that later sent it to an untimely grave because of the extension to contiguous structures.

The causes, course of the disease and symptoms are given.

In the treatment great importance is attached to the inflation of the Eustachian tube and middle ear. The catheter is rarely used. The use of Bishop's improved inflator is advocated.

Any nasal or naso-pharyngeal abnormalities should be corrected.

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Dr. D. S. Humphreys, of Greenwood, Miss., writes to the *Med. Record* as follows: "I was called some time ago to remove a cotton seed from the nostril of a three-year-old child, which I did very easily and quickly by the following method: The nose-piece of an ordinary Politzer's air-bag was inserted into the nostril on the side opposite to the offending substance and the bag suddenly compressed, when out, half way across the floor, flew the cotton seed.

"It is an ideal method, as the screaming of the frightened child closes the posterior nares and forces the air back through the other nostril."

---

Never give a child a bath immediately after a meal.

---

Headaches at the menopause, with the flushes followed by perspiration, are relieved with gelsemium.

---

In giving cimicifuga in the treatment of chorea, remember that a decoction of the root is the most active form.

---

Thyroid extract in mammary cancer lessens the pain and the discharge, and seemingly has an inhibitory action on the malignant growth.

---

In eczema of the scalp in young children, give berberis aquifolium. It is nearly a specific. The application of bismuth and lanolin externally will assist materially.

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Take five parts of camphorated chloral, 30 parts of glycerin, and 10 parts of the oil of almonds, saturate a piece of cotton with this and apply into a painful ear, and it will cure as if by magic.

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THE
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# Editorial.

## VACCINATING A NATION.

It would at this period of the world's history seem a piece of folly on the part of anyone to deny the efficacy of vaccination on the arrest of smallpox. Yet, there are not a few who are guilty of this supreme act of folly. To such we would commend the facts contained in this brief editorial which are obtained from an article by Dr. George G. Groff, and which appeared in the *Medical News* for November last. At the conclusion of the war with Spain, the Americans on taking over fully the government of the Island of Porto Rico, found smallpox epidemic. At the end of January, 1899, the Governor-General ordered a general vaccination of the inhabitants. For some reason not quite clear to us, it was thought not advisable to buy the vaccine from the United States, so it became necessary to start a "vaccine farm." At first all animals were tested with tuberculin, but no reactions were obtained, so it was concluded that tuberculosis does not occur among the unconfined cattle of the Island. The animals were not stabled either before or after inoculation. The lymph was collected upon points, dried, wrapped in bundles of one hundred and dated, and mailed daily to

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the vaccine stations. The result was simply astonishing, and may be put down as a record breaker in stamping out the disease. Letters were sent to all physicians and to all the alcaldes asking their co-operation. This action resulted in the people appearing on the date ordered and submitting themselves to vaccination.

The instructions to public vaccinators required them (1) to wear clean white clothing and to disinfect their hands before operation; (2) to scrub each subject's arm with soap and water and then with bichloride solution; (3) to use as scarifiers either needles kept in 1 to 40 carbolic solution (one vaccination only with each needle) or a lancet dipped in 1 to 20 carbolic solution and passed through an alcohol flame before vaccination; (4) to make two scarifications on each subject, the vaccine point to be wet with sterile water, rubbed thoroughly over the scarifications and allowed to dry thoroughly; (5) to visit every vaccinated person a second time, and either give a certificate or re-vaccinate, and (6) to report daily upon the work of the day and the needs of the morrow.

Every post surgeon was made an inspector of vaccination, and required to enforce the instructions to vaccinators, and to report daily to his director. The director, in his turn, reported weekly to the chief surgeon. In three working months 800,000 people were vaccinated at a cost of $32,000, and at the date of writing, October 20, Dr. Groff says that not a single case of smallpox was known to either the civil or military authorities in any part of the island. The work was accomplished without a disturbance of any sort, though some natives had excuses to offer for not coming out promptly on the call of the alcalde.

If our virus were always employed with the scrupulous technique practiced in Puerto Rico, the anti-vaccinationists would soon perish for want of modern instances. Municipal health authorities might also derive some advantage in the same direction by importing a few alcaldes.

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## DR. WILLIAM OSLER TO MEDICAL STUDENTS.

On the occasion of a professional visit to Columbus recently, the distinguished Canadian teacher and author, Dr. William Osler, delivered a clinical lecture before the students of the Ohio Medical University. It is needless to say that the students and the physicians present greatly appreciated the opportunity of hearing him. His closing remarks were of such a character as to be of interest to the profession in general, as well as to students.

"Gentlemen, the most unhappy day of my life was when I sold my brains to the publishers. For a long time they had been after me to write a text-book, but I resisted. I never thought text-books so very much. I was tired of them, and thought I was fitted for something better than writing a text-book, but finally I consented. I must have had neurasthenia or something else, and I beg your pardon for ever having consented to write a book. I have been sorry for students ever since, and trust when Osler goes out of vogue some one will have ready an easier text.

"I am very glad indeed to have met you all. I never meet a crowd of medical students but I think of Abernethy's remark, 'Good God! What will become of you all?' I know what will become of you. You will all do well. The medical profession is one in which every man can make a success, that is to say, he can be successful if he will work hard, study hard and take an interest in his patients, not that they are patients, but because of his duty to mankind, will succeed. Practice not only with your head but with your heart also.

"Avoid professional jealousies and bitterness. Gad, doctors are worse than parsons in engendering ill-feeling among themselves. When you locate, look up all the respectable doctors and leave your card. Tell them that you are going to locate, and that you expect to deal squarely, and you will find they will treat you right. Shut up at once the patient who would tell you of the faults of a professional brother. They will go to another and say the same of you. If you go with the seamy side out, the same

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side will be turned toward you. Go with the woolly side out and all will be well, and success crown your efforts."

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The Philadelphia *Medical Times* has drawn attention to the inconvenient and unscientific habit of labeling diseases with the name of its discoverer. It alludes to an article in a recent number of the *Archives de Medicine Experimentale*, headed "Curable Gangrene of the Lung of Lasègue." This article has a sub-heading, "A variety of Gangrene of the Lung depending on the modification of the dilated Extremities of the Bronchi of Briquet." One is tempted to ask who Lasègue and Briquet were, and what excuse there was for tacking their names on to gangrene of the lung. We imagine that this labeling process is due to several reasons. One is that the sister sciences honor discoverers in a similar manner; another is that grateful pupils have chosen this method of honoring their masters and perpetuating their names. Many other possibilities of origin exist. One fact for which we may be devoutly thankful is that in most instances these remarkable men have had remarkable names. It would have been distressing if we had had five or six Smith's diseases, or had had to remember that P. Q. Jones' disease was a warty affection of the feet, whilst S. K. Jones' was impacted ear wax.

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## THE WAR IN SOUTH AFRICA.

We believe that our readers, whether they be surgical enthusiasts or not, are deeply interested in the wounds inflicted on our brave troops, and will read with absorbing interest the details which will be found below. This is the first great war which has taken place since the introduction of the new Magazine Rifle, with which most of the Boers, as well as the Brirish, are armed. Their well-known accuracy of fire is, of course, responsible for the large number of killed and wounded, which, we should judge, is unusually large when the number engaged is taken into consideration. It would seem as if exceptionally good results are likely to be

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obtained, not only in chest wounds, but in perforating abdominal wounds, and in cases even where the bones are shattered. When one considers the perfect storm of bullets which can be thrown upon a force, advancing across an open plain, by magazine rifles and machine guns, it would seem as if men must be endowed with more than ordinary courage to face it.

Under date of Orange River, Dec. 3, 1899, Mr. Makins, F.R.C.S., Consulting Surgeon with the Field Force in South Africa, writes to the British *Medical Journal*. We make a few extracts:

I may say at once that the immense majority of the the wounds have been inflicted by the Mauser or Lee-Metford bullets, and a small proportion by Martini bullets and large projectiles. I shall refer to the wounds by the small calibre bullets only.

*The Mauser and Lee-Metford.*—A wounded Boer referred to the Lee-Metford as a "gentlemanly bullet," and this remark is equally applicable to the Mauser. The wounds made by them are small, clean and little disposed to suppurate, and the tendency to suppuration is no doubt decreased by the excellent physical condition of the patients and the healthiness of the district. Shock as a sign has been conspicuous by its absence even in the most serious cases, and gives little or no aid in the diagnosis of visceral injury. Retained bullets are comparatively uncommon, no doubt on account of the fact that most of the men have been wounded in rapid advances. The bullets met with have been little deformed, unless they have struck stones before entering, and I have seen no single instance which would suggest the use of either flattened or so-called explosive bullets among the wounded here. The only large exit wounds have been one or two opposite comminuted fractures.

*Wounds of Vessels.*—Wounds of the soft parts are, as a rule, simple tracks, with but little difference between the aperture of entry and exit; such wounds heal in a few days with no surrounding induration or œdema. In cases where vessels of any size are implicated, especially in such regions as beneath the deltoid, gluteus maximus, or the two layers of the calf, considerable deep hæmorrhages often occur and are rapidly absorbed, but free hæmorrhage from the wound itself is rare

Wounds of great vessels naturally have not come under

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our observation in any number, but one patient died in a few seconds soon after admission with sudden swelling of the belly; another had a swelling, some dullness, and a thrill over the area of the innominate artery; and one case of fractured femur had apparently an injury to the femoral vein. This may, I think, be considered a very small proportion out of the total number of cases.

*Wounds of Nerves.*—Wounds of individual nerves will, I think, be a great feature of the campaign. Wounds of the median, ulnar, musculo-spiral alone, or in various combinations, are common; I have seen two isolated injuries to the great sciatic, and one of the spinal accessory nerve. In some cases the evidence is in favour of complete section, in others diminution of power combined with great hyperæsthesia suggests contusion or partial laceration.

*Fractures and Wounds of Joints.*—Fractures are for the most part transverse, or the bones are tunnelled with a simple track. Comminution in the series seen here is distinctly rare, either in the flat or long bones, and certainly a large number of the wounds have been inflicted well within the 1,000 yards range.

Joint perforations, especially of the knee, are fairly common. The cases left us too soon to form any opinion as to their permanent results, but everything pointed to these concurring with those to be seen at Wynberg, where little functional or structural alteration is to be observed.

*Wounds of the Head.*—The proportion of wounds of the head is small; some fractures with much bursting at the wound of exit have been met with; naturally many may have been left on the field, and I think only some three or four have come down here. Many extraordinary cases will no doubt be recorded; thus, for example, entry in the median line below the chin, perforation of the floor of the mouth and tongue, the alveolar process of the superior maxilla, traverse of the floor of the orbit, injury to the back of the globe, perforation of the anterior fossa and escape through the frontal bone at the margin of the hairy scalp. The patient thus wounded left here on the fourth day without any symptoms. Several others of a similar but slightly less complicated nature have been seen.

*Wounds of the Neck.*—Wounds of the neck have been very common, but we have seen none implicating the great vessels excepting the one already referred to. A number of wounds of the posterior triangle with mixed nerve injuries are, however, under treatment.

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The small bullet effects the most complete transverse section of the spinal cord. No fewer than 10 cases of paraplegia have come down from the front, usually complete, symmetrical, and with total absence of patellar reflex. Time only will show how complete these injuries are, but one from Belmont died here on the fourth day; the remainder from Modder River have gone down to Wynberg.

*Perforating Wounds of the Chest.*—Perforating wounds of the chest have been numerous, producing remarkably slight symptoms. Hæmoptysis, slight in degree, persisting one to three days, occurs in one-third of the cases; a few have signs of blood in the pleura and a few have cellular emphysema. The only constant sign is a want of respiratory mobility on the injured side and some diminution of breath sounds.

*Wounds of the Abdomen.*—I have seen fourteen wounds of the abdomen; of these, 10 have exhibited no serious symptoms, and will probably all get well. The pulses have not risen above 80, and the only signs have been some local tenderness, rigidity and deficient mobility of the belly; all came here on the third day after the injury; slight vomiting occurred in some of them before arrival. In two cases the injury probably implicated the kidney and in one the liver, but in all three the hæmorrhage must have been very slight.

*Abdominal Sections.*—In four instances peritoneal infection had already occurred, three of the patients being Boers and one an English officer. The latter had suffered an injury to the cæcum; abdominal section was done on the third day, and he is doing well at the end of the week, but still with a discharging wound; abdominal section was also done for a partly intraperitoneal, partly retroperitoneal, injury to ascending colon; retrocolic extravasation and emphysema had already occurred. The wound was found and the affected area drained; the patient is still living (eighth day), but will certainly succumb to sepsis from the large foul cavity in his loin. The remaining 2 were cases of injury to the small intestine. One was too ill for operation. The second was opened, and three perforations in the jejunum were discovered and sutured. Purulent inflammation had, however, already spread as low as the pelvis, and the patient died the day following the operation. All that can be said from this experience is that no patient should be operated upon from the mere fact of apparent traverse of the belly by a Mauser or Lee-Metford bullet. It is possible that if the

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patients could have been seen sooner operation might have been earlier decided upon in the 4 cases who were so treated; but the great number of wounded at the front rendered this an impossibility.

Another correspondent, writing from Cape Town under date Dec. 6, says:

*Abdominal Wounds.*—Except as regards these compound fractures, and that despair of military surgery, the perforating abdominal wound, the results continue to be remarkably good. One case of the latter class I saw, however, which is doing admirably. A Mauser bullet had entered on the left side just above the pelvic brim, and had emerged on the opposite side by way of a hole in the ileum itself. It had evidently perforated the posterior wall of the bladder, and established a communication between that viscus and the rectum, for the man was, and still is, passing all his urine *per rectum*. Very little extravasation could have taken place before the securing of the fistulous communication, although the patient had pretty severe peritonitis. This has now subsided, and the patient is doing splendidly. Mr. Treves saw him, and advised that no operation should be undertaken.

*Head Iniuries.*—The head injuries have done, on the whole, very well. I saw one very successful case. The bullet had entered the cranium near the middle line, and had splintered the bone in a depressed gutter down along the course of the upper part of the Rolandic fissure. One of the civilian surgeons trephined, and removed a large number of spicules and small plates of bone. The patient had typical Jacksonian convulsions before operation, and for two days later, but for four days these have ceased; his temperature has gone down to normal, and he is doing very well. He is somewhat dull, but has never been aphasic. Another patient who was trephined in the occipital region has done very well, no symptoms remaining except some photophobia.

*Wound of the Spine.*—Another case presents some features of interest. A bullet had entered almost exactly in the mid-spinal line at the level of the sixth cervical vertebra, and had travelled downwards, the man being lying down at the time, and lodged at the level of the seventh dorsal, whence it was removed. The lower extremities are paralysed, there is overflow dribbling from the bladder, and total anæsthesia as high as the fifth rib, with a zone of hyperæsthesia above. This zone is now about two fingers breadth, and the

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hyperæsthesia is not nearly so intense as before. When the case first came in the hyperæsthetic tract was very much wider; no expansion of the anæsthesia has so occurred; no depression can be discovered. He is being treated expectantly with an idea of possibly doing a laminectomy later.

The same correspondent, writing from Cape Town under date of Dec. 13, says of No. 2 Hospital at Wynberg:

There is a large proportion of perforating abdominal wounds—9 are in at present. Curiously enough, most of them have done well under expectant treatment, a result at variance with most past experience. Colonel Duke attributes this to the fact that most of the men sustained their injuries whilst fasting, and thinks that the punctures inflicted on hollow viscera close up, under these circumstances, before extravasation can take place. Five spinal cases are in the hospital, with complete paraplegia. Laminectomy has been performed on one without result. The perforating chest wounds have done well almost uniformly. One case I saw was interesting. A Mauser bullet had entered just to the right of the thyroid cartilage and emerged slightly to the right of the ligamentum nuchæ, an inch below the occipital protuberance. No symptoms followed. In another case a Mauser bullet had entered the malar bone on one side, and emerged in the temporal region on the other. The result has been anosmia and diplopia, but no loss of visual acuity.

Surgeon C. Marsh Bradnell, R.N., with Lord Methuen's force, writing under date of Nov. 30, 1899, at the Battle of Modder River, says:

*The Mauser and the Lee-Metford.*—The next morning we quietly marched into the town and occupied it. The day was spent in burying the dead. The field hospital was very crowded this morning, over 400 dead and wounded. The wounds produced by the Mauser bullets are all that could be desired; the entrance and exit are practically of the same size and very minute. Most of the patients make an uninterrupted recovery. It is a more humane bullet than our own Lee-Metford for two reasons: its calibre is less and its velocity is considerably higher.

Under date of December 13th, the same correspondent, writing of the battle of Magersfontein, says:

Yesterday we attempted to oust the enemy from their position in the Spytfontein and Magersfontein kopjes, but

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I regret to say we signally failed; and to-day we are in the same position, but with a loss of 1,000 men; there are about 700 dead and wounded and about 300 missing. The Black Watch lost very severely 21 out of 29 officers. It seems that they advanced in the night in quarter column, and at dawn were still in this formation, and within easy range of the enemy's rifle fire. The Boer losses it is quite impossible to calculate.

Our lyddite shell from the 4.7 naval gun has a magnificent effect to the eye, sending up a vertical column of earth and *débris* to a height of about 50 or 60 yards. It is claimed by the inventor to kill by concussion within a radius of 34 yards from the site of the explosion. The shell weighs 46 lbs., and is charged with the high explosive called lyddite —chemically a picrate.

I have only witnessed the effect of the shock of the explosion once; it was in the person of a Highlander. A shell exploded about ten yards over his head, he was untouched by any fragments, but the concussion must have produced some curious pathological change in his nervous system, as he has never ceased (now ten hours) swaying his head to and fro with a pendulum-like motion similar to that of the china dolls with the nodding head so commonly seen in the London streets. His intellectual faculties have also been considerably disturbed, as he is only half rational.

*The Glories of War.*—Last night there were hundreds of our dead and dying left in the field; in fact, it has taken two days to collect them, and much suffering has been entailed. One poor fellow walked into our lines with a towel on the end of his rifle, he was raving mad, and had been wandering about for hours with a portion of his frontal lobe protruding through a Mauser exit wound in the fore part of his skull.

The medical men have had a terrible time of it—working incessantly for thirty-six hours. The field hospital presents a sad but impressive sight; one mass of wounded inside, rows and rows of dead outside; it is a sight, I think, would cure once and for all those worthy individuals who talk of the "glories of war."

December 14th, 1899.

*Total Losses at Magersfontein.*—Since writing the above some more dead and wounded have been brought in, bringing our total losses in the engagement at Magersfontein up

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to 1,100 dead and wounded. I have also heard that one of the army medical officers to whom permission was given by the Boers to go up to their lines and attend to our own wounded, has been made a prisoner of war, owing to the fact that a revolver was found on his person. The two Generals have communicated with each other concerning him, but General Cronje remains firm, and claims that men and officers wearing the Red Cross should be unarmed. I know the officer personally, and regret his capture, but at the same time all will agree that General Cronje is within his right.

A special correspondent of the same journal, under date Capetown, December 20th, 1899, says:

*The Base Hospitals.*—The work at the base is now becoming very heavy indeed, consignments from Methuen's column arriving in rapid succession. It is satisfactory, however, to report that the service is everywhere standing the strain.

*Medical Cases.*—Medical cases, as might be expected, are beginning to come in somewhat more freely from Methuen's column. Almost all the cases are either rheumatism or dysentery. The former come down mostly in a subacute condition, with joint pains and slightly elevated temperature. They have, of course, all undergone some treatment above. For the most part they are doing well, and no large proportion develop heart complications. The dysenteric cases are numerous, and in this connection it may be mentioned that the affection known as "dysentery" has by no means the typical character of the endemic dysentery of India and other tropical climates. The manifestations are not so severe, neither is the prognosis, either as regards death or chronicity, so bad.

*Surgical Cases.*—On the surgical side the cases coming in present much of the routine character to which I have before alluded. The remarkable success obtained with the perforating thoracic wounds is still evident, the pleuritic effusion developed in a few cases generally becoming rapidly absorbed. For this one has to thank the splendid physique of most of the men (a factor largely dependent on the reserve element), the excellent hygienic conditions and the good and abundant food. The record of cases of perforating abdominal wound continues to improve upon the experience of the speakers at the Portsmouth meeting of the British Medical Association. Civil Surgeon Hanwell pointed out one case which is convalescing steadily with merely a symp-

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tom; six cases of this class have so far done well. Under the care of the same civil surgeon is another case of much interest. A bullet had entered the buttock and emerged in the left groin, perforating the lower and posterior aspect of the bladder, going through the attachment of the internal oblique, and smashing the left pubic ramus. Of course there has been external extravasation on the left side, but the exit for the urine has been and is free enough, owing to extensive sloughing of the exit wound. Now there is an aperture large enough to insert three or four fingers, through which the shattered ramus and the opening to the bladder can be clearly seen. The sloughing appears to be ceasing, and there is some attempt at granulation, but the wound is badly septic, and the patient in a marked septicæmic condition. At first a drainage tube was inserted, but this became so constantly blocked with sloughing fragments that it was discontinued, and Mr. Hanwell is now irrigating through the bladder with boracic lotion.

The spinal cases are the most disheartening things one sees in the hospitals, although they bring out the excellent nursing which is evident everywhere. In one, which became the subject of a necropsy, the cord was found literally smashed for over an inch.

Regarding the wounded at the Battle of Colenso, a correspondent writes as follows:

*Nature of Wounds*—The Fifth Brigade Field Hospital, under the command of Major G. H. Younge, R.A.M.C., had quickly 24 officers and 285 non-commissioned officers and men admitted with bullet wounds. The following analysis of these wounds, according to the region involved, is interesting: Head 19, face 7, neck 3, back and spine 20, upper extremity 76, lower extremity 118, other wounds 6.

From this it will be seen that wounds of the lower extremity greatly predominated. Of the 309, only 8 were returned as shell wounds; the remainder were without exception caused by Mauser bullets. The wounds caused by these bullets were humane in the extreme. The wounds both of entrance and of exit were small, and presented a clean punched-out appearance, being almost entirely free from contusion or laceration. Amongst the cases brought to hospital hæmorrhage was conspicuous by its absence.

In Major Younge's field hospital only 4 cases of gunshot fracture were admitted—1 of the femur, 1 of the humerus, and 2 of both bones of the leg. In none of these were the

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bones extensively comminuted, and it is more than probable that all 4 cases will recover with useful limbs.

Many of the wounds were curious and interesting. One man presented symmetrical Mauser bullet wounds one inch below the centre of each clavicle. Both bullets passed directly backwards, but no wounds of exit could be found. In another case a man was struck whilst lying down. The bullet entered near the centre of the parietal bone, passed downwards and forwards through the brain, the orbit, and the hard palate, and was found projecting beneath the skin behind the symphysis menti, from which region it was removed without difficulty by Major F. T. Wilkinson, R.A.M.C. There was extensive effusion of blood within the orbit, which caused marked protrusion of the eye and lids. The patient was perfectly conscious, could give an accurate account of how he was wounded, and on the following morning was able to walk without difficulty to the stretcher on whice he was carried to the hospital train.

*Treatment in the Field Hospitals.*—In only a few cases was it found necessary to perform operations in the field hospitals. As the cases arrived the wounds were washed with perchloride lotion and dressed with double cyanide wool and gauze. Long before night fell the whole of the wounded, exceeding 600 in number, were comfortably lodged in the field hospitals.

On the day following the battle the wounded were transferred to the staticnary and base hospitals with a celerity which was absolutely marvellous. In effecting the transfer the greatest assistance was given by the Volunteer Ambulance Corps of 1,000 men, which was organised at Maritzburg by Colonel T. J. Gallwey, C.B., R.A.M.C.

*The Conduct of the R.A.M.C. under Fire.*—During the action many acts of heroism were performed by both officers and men of the R.A.M.C. Conspicuous amongst these was that of Major W. Babtie, C.M.G., R.A.M.C., who rode through a tempest of bullets to succour a number of men of the Royal Artillery, who lay wounded and exposed to the enemy's fire. Wherever the fire was hottest there were to be found medical officers attending to and dressing the wounded with as much coolness and skill as if they were in the wards of a hospital.

In all I saw 3 cases which were brought to the field hospital without dressings, and in almost every case the dressings were applied with a neatness and precision which

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would have done credit to any hospital. The rapidity with which the wounded were dressed and removed from the field by the bearer companies was the subject of favourable comment on all sides. The ambulances were several times fired on by the enemy's guns and several of them were damaged by fragments of shell, yet the medical officers worked steadily on with a devotion and heroism which was beyond all praise.

# Book Reviews.

**Progressive Medicine.**—A quarterly digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Volume IV., December, 1899. Lea Brothers and Company, Philadelphia, Pa., 1899.

Promptness is a great deal in the issue of such a volume as this one. It is therefore commendable that it was ready for delivery to subscribers early in January. Diseases of the digestive tract and allied organs, the Liver, Pancreas and Peritoneum—Genito-Urinary diseases in the male, and Syphilis—fractures, dislocations, amputations, surgery of the extremities and orthopedics, Diseases of the kidneys — Physiology — Anatomy — Hygiene, Practical Therapeutics—Referendum. Some of the articles are extremely well illustrated, and the type and paper are most pleasant to the eye. The value of this quarterly is well maintained, and without hesitation we commend it to our readers.

F. W. C.

**Essentials of Medical Chemistry,** organic and inorganic, containing also questions of Medical Physics, Chemical Philosophy, Analytical Processes, Toxicology. Prepared specially for students of Medicine, by Lawrence Wolff. M.D., demonstrator of Chemistry Jefferson Medical College. 5th edition, thoroughly revised by Smith Ely Jelliffe, M.D., Ph.D. Philadelphia: W. B. Saunders, 925 Walnut Street, 1899, $1.00 nett. Canadian agents, J. A. Carveth & Co., Toronto.

The question compends issued by W. B. Saunders on the various subjects embraced in a Medical curriculum have for some years occupied a unique place in Medical literature. Some teachers have not taken kindly to them, as it appeared to them as if some subjects did not receive that thoroughness of treatment which they considered was essential. The majority, however, felt that, not only were they thorough and up to date, but that they filled a long-felt want. This has always been our view, and those

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for whom they have been prepared have purchased over 175,000 copies, a sure indication of their appreciation of them. The chapters dealing with Organic Chemistry have in this edition been considerably modified and enlarged, more particularly in the discussion of Physiological Chemistry. In this branch of the subject new facts of vital importance are rapidly accumulating, and an attempt has been made to present a brief outline of the present status of our knowledge of the chemical constituents of the human body.

F. W. C.

**A Manual of the Diagnosis and Treatment of the Diseases of the Eye.** By Edward Jackson, A.M., M.D., Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic, formerly Chairman of the Section of Ophthalmology of the American Medical Association, Member of the American Ophthalmological Society, Fellow and ex-President of the American Academy of Medicine. With 178 illustrations and 2 colored plates. W. B. Saunders, Philadelphia, 1900. Canadian agents, J. A. Carveth, Toronto. Price, $2.50.

Among the many text-books treating of ophthalmology that have been published of late, there is none better adapted to the requirements of the medical student than that just written by Dr. Jackson.

This manual deals mainly with the diseases of the eye from the standpoint of the clinical observer, and is not clogged with endless classifications and unproven theories; the plates, too, are from drawings by the author, and are clear and instructive.

To the student who intends to give his attention entirely to ophthalmology, the full bibliography given at the end of each chapter is of great value. Taken in its entirety, the book can hardly be too highly commended as a good, safe guide to a knowledge of the diseases of the eye. The very low price of the book brings it within the reach of every medical student.

G. H. M.

**A Text-Book of the Practice of Medicine.** By James M. Anders, M.D., Ph.D., LL.D., Professor of the Practice of Medicine and of Clinical Medicine in the Medico-Chirurgical College, Philadelphia; Attending Physician to the Medico-Chirurgical and Samaritan Hospitals, Philadelphia. Illustrated. Third edition revised. Cloth, $5.50; sheep or half morocco, $6.50. W. B. Saunders, 925 Walnut street, Philadelphia, 1899. Canadian agents, J. A. Carveth & Co., Toronto, Ont.

The popularity of this book is evidenced by the fact that it is less than a year since the second edition was issued. In the present issue a very thorough revision has been made and all recent advances incorporated. Among the new subjects introduced are: Glandular Fever, Ether Pneumonia, Splenic Anæmia, Meralgia,

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Paraesthetica and Periodic Paralysis. The following have been rewritten: The Plague, Malta Fever, Diseases of the Thymus Gland, The Liver Cirrhoses and Progressive Spinal Muscular Atrophy. The articles extensively revised are: Typhoid Fever, Yellow Fever, Lobar Pneumonia, Dengue, Tuberculosis, Diabetes Mellitus, Gout, Arthritis Deformans, Autumnal Catarrh, the Diseases of the Circulatory System, more particularly Hypertrophy and Dilatation of the Heart, Arterio Sclerosis and Thoracic Aneurism, Pancreatic Hemorrhage, Jaundice, Acute Peritonitis, Acute Yellow Atrophy, Haematoma of the Dura Mater and Sclerosis of the Brain.

The articles have been condensed here and there, so that with the numerous additions the book is not increased in size. The division of each subject is indicated in large type, which accentuates and confines the subdivisions in a way to aid the study of the subject, and will be found very useful to the student. Illustrations, colored and otherwise, are numerous, and add greatly to the attractiveness and usefulness of the book. A prominent feature is the large number of differential tables which are found throughout the book in connection with the more important subjects.

We notice an error which might confuse the beginner in the table showing the diagnosis between Pleurisy with effusion and Primary Lobar Pneumonia. Pleurisy is said to have sputum containing the pneumococcus and pneumonia not.

Dr. Anders has presented us with a first-class text-book entirely up to date, giving evidence of a thorough consultation of all the modern advanced works and most recent literature, and we know of no better work on the Practice of Medicine for both student and practitioner than his.

J. B. McC.

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# PUBLISHERS DEPARTMENT.

## *THE ART AMATEUR* FOR FEBRUARY.

It has become evident, according to *The Art Amateur*, that the only way to raise the necessary money for The Dewey Arch is by a popular national subscription, to which everybody may contribute; and the magazine, in its February number, undertakes to be the first periodical to start such a subscription. "It will accept all sums, large or small, will publish the donors' names and the amount of their subscriptions, and will bank the money received until such time as it can be used for the actual construction of the Arch." It adds that, "It is now for the press in general to follow or lead."

"The erection of The Dewey Arch," *The Art Amateur* says, "will be a first step in the adornment of the metropolis, and will furnish a much-needed object lesson for the entire country." We cannot afford to dispense with any means of popular education which has been found indispensable by other great nations. The multiplication of colleges, picture galleries and museums, though greatly to be desired, cannot have such an influence upon the masses as the daily view of an imposing monument, such as the Arch, magnificently decorated with sculptures whose meaning is apparent to every passer-by, will be when finished.

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The Sloane Museum in London, with its wreck of a famous Reynolds and the best preserved series of Hogarths extant, is described in *The London Letter* by Montague Marks. There is "A Talk on Miniature Painting," by Mr. Theodore Wust, and a series of amusing miniatures by the same clever artist, illustrating episodes in the life of a certain New York art critic. Mr. William Patten writes of "Illustrations in the Magazines." As to "Art in the Home," a paper by Mr. John W. Van Oost the editor, which was read at the last Architectural League Dinner, makes many pertinent suggestions, notably this: That "good taste is cheap when you've got it, but mighty dear when you haven't." "The Ceramic Decorator" and the other departments are well filled as usual. The color study is "The Call to Dinner," by Henry Mosler. In all respects this is an admirable number. (John W. Van Oost, publisher, 23 Union Square, N. Y. C. Price, 35 cents.)

## LITERARY NOTES.

*The Living Age* promises a paper on Robert Louis Stevenson's Letters, by Augustine Birrell, in its issue for February 10. There could scarcely be a more delightful combination of author and subject.

"The Ghost of Dr. Harris," a hitherto unpublished sketch by Nathaniel Hawthorne, will be reprinted in *The Living Age* for February 10 from *The Nineteenth Century*.

A series of South African Reminiscences, by Sir John Robinson, formerly Governor of Natal, is begun in *The Living Age* for January 27. Natal, from a woman's point of view, will be presented in a paper called "Natal Memories," by Lady Broome, in *The Living Age* for February 10.

A biographical sketch of President Loubet, by Emily Crawford, will appear in *The Living Age* for February 3. It gives an intimate and charming view of the French President in his personal and family relations.


## SANMETTO AS AN INTERNAL REMEDY FOR GENITO-URINARY CONDITIONS.

While fully realizing the superfluity of further testimonials concerning a remedy so well and favorably known to the entire medical profession as is Sanmetto, yet as I possess an extended knowledge of its reliability based on several years' clinical experience and on the treatment of hundreds of cases in which it has proven itself eminently fitted to lighten the cares of the genito-urinary surgeon, I am perhaps invested with a certain authority which should permit me the privilege of adding my meed of praise. In all the inflammatory conditions of the genito-urinary tract, from the meatus to the pelvis of the kidney, the administration of Sanmetto is invariably beneficial. It not only renders the urine bland and unirritating, but also exerts a specific action on the inflamed tissues, soothing and restoring the tonicity of the parts. Its tonic action on the prostate is of such a nature that it proves of equal advantage in cases of either hyperplasia or of atrophy, and there is no remedy so uniformly successful in the treatment of atonic impotency or pre senility. I have found it of inestimable service in the preliminary preparation of cases requiring surgical interference, and, combined with salol, use it constan ly to secure urinary anti sepsis. I am fully of the opinion that Sanmetto represents all that could be hoped for or desired as an internal remedy for genito-urinary conditions.

H. R. WEBER, M.D.,
Univ. Md. School of Medicine, 1886,
Member Am. Med. Assoc., etc.

CHICAGO, ILL.


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CANADA
# MEDICAL RECORD

MARCH, 1900

## Original Communications.

### THE SYSTEM OF TRAINING MEN IN THE FIRST AID TO THE WOUNDED.

A LECTURE GIVEN BY SURGEON-LIEUT COL. CODD, R. C. D. TO A CLASS IN "B" SQUADRON, R. C. D., AT WINNIPEG.

*Officers and Non-Commissioned Officers:—*

I have been requested by the officer commanding to give you to-day a lecture on the subject of "The First Aid to the Wounded," but as I lectured pretty fully to you on this particular subject last winter, I think I better term my lecture on this occasion "The System of Training Men in the First Aid to the Wounded," giving its history briefly and a few practical remarks on the subject.

The method of attending to the sick and wounded in the British Army goes back to the year 1745, and even earlier than that, but in that year Sir John Pringle, then Surgeon-General, organized a system for Regimental, Field and General Hospitals. The first appointments of medical officers and hospitals in the field was in the Peninsular War; these were under the control of Sir John McGregor, then P. M. O.

At this time there were no Ambulance Corps, in fact the assistance to the wounded in any way must have been of a most primitive nature. The improvements since, as you will observe as I proceed, are very great and of a modern nature.

In 1812 a Corps called the Royal Waggon Train was organized for conveying the sick, but this was also used for

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commissariat purposes, which proved unsatisfactory in regard to helping the sick, and was consequently disbanded in the year 1833.

In 1854, at the outbreak of the Crimean War, a Hospital Conveyance Corps was organized, which consisted of non-effective men, such as pensioners, convalescents and servants. These men, however, were not properly trained and proved unsatisfactory, and disbanded.

There were other methods tried for the assistance of the wounded, but none appeared to work satisfactorily. In 1855 the first Medical Staff Corps was organized, but this again was apparently badly trained for the purpose, being at the same time employed for general hospital purposes; this did not suit the requirements, and was done away with after a very short trial.

In connection with hospital training and nursing at this date, I must not omit to mention the valuable services of Miss Florence Nightingale, who offered her services to the War Office to proceed with her staff of thirty-eight nurses to the Crimea and nurse the sick and wounded. Her offer was accepted. Miss Nightingale and her assistants did most noble work in relieving the sufferings of the wounded soldiers, which was recognized throughout England and France by a subscription of £20,000 to found The Nightingale Home for training nurses. Miss Nightingale was, I believe, the first English lady who entered upon the work of hospital nursing, which has now become so popular in civil life and hospitals. This same year the Army Hospital Corps was established as a complete military organization; this was the real beginning of an Ambulance System; the members were trained for three (3) months in hospital duties before joining this Corps. Then in 1858 there was a Royal Commission, under Sir Sidney Herbert, to report upon the general sanitary state of the army and re-organize the Medical Service as well as establishing a practical medical school for training medical officers, through which all medical officers had and have now to pass for appointments in the army.

In 1873 the Regimental System was abolished and medical officers placed in one department, which system, I

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presume, will be thoroughly established in our Dominion Service in the near future.

In 1883 General and Field Hospitals and Bearer Companies were established by Lord Morley, and in 1884 the officers of the Medical Department and the Army Hospital Corps were termed the Medical Staff Corps.

There is also the British Red Cross Society, an excellent organization which has for years past done great service in the wars in South Africa and other campaigns. This Society has lately permitted a branch to be established in Canada, which, no doubt, would be of great assistance to us in the event of any war.

A Volunteer Medical Staff Corps was formed in England in 1886, and is instructed by a staff from the Regular Service. There is now in London the Volunteer Ambulance School of Instruction, which is an excellent institution, and open to any medical officers who desire to qualify in ambuance work.

Then, again, there is also in England the Militia Medical Staff Corps, which was organized in 1891 ; they are trained annually and receive pay. The officers rank from Surgeon-Lieutenant to Surgeon-Major and Non-Coms. to that of Sergeant.

This I may say is a synopsis of the history of hospital and ambulance organization.

To be proficient in their duties, I need not tell you, it is necessary to undergo considerable instruction and training, which in this Corps involves upon me to teach you to the best of my ability and as circumstances from time to time may permit. In the first instance it is necessary for the ambulance man to understand something about the anatomy of the human body, the location of the most important internal organs and blood vessels ; this will be taught you by lectures and illustrations on charts. During the present term I propose to instruct you on the anatomical outlines of the human body, the principal organs, the heart, larger blood vessels, and the circulation of the blood, the lungs and a brief description of the nervous system. You will require to know the nature of the principal wounds a soldier is likely

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to receive, how to dress them and arrest bleeding. Fractures, how to treat them on the field, bandaging, what to do in emergency cases, *i.e.*, poisoning and drowning, will be taught you. These subjects are all instructive to officers as well as men. I think every officer should know something of how to act in a case of emergency, and have some knowledge of ambulance work, more especially that which pertains to the actual work on the field, such as the mode of collecting the wounded and their conveyance from the field and their disposal afterwards.

In this particular respect I might first describe briefly the medical equipment for the field in war time. This consists of field and stationary hospitals, bearer companies, ambulances, medical and surgical supplies and appliances according to the nature of the country, climate and probable length of the campaign. These would all be collected at the seat of mobilization under the charge of the P. M. O., who is responsible to the Surgeon-Major General. The P. M. O. appoints Surgeons to the different corps or units in the field ; these have charge and control of the bearer companies and ambulances placed at their disposal.

At the field hospital there is a staff of medical officers, the number being in accordance with requirements.

The stationary hospital on the line to the rear and the general hospital at the base are supplied with the medical staff proper, and are under the control of the Surgeon-Major General and the general officer commanding.

The transports necessary for hospitals, hospital supplies and conveyance of the sick and wounded to or from any distance is performed in the British Army by the Army Service Corps, but in Canada at present we have to depend on other means, generally local, for this purpose.

From the actual battle field to the base or extreme rear there is what is called three (3) lines of assistance for the wounded. The first line of assistance is that of carrying off the wounded to the collecting station. This is done by a non-com. officer and bearers under the direction of a surgeon. This station is placed in as protected a position as possible, and the wounded receive temporary relief. From here they

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are conveyed by an ambulance or stretchers to the dressing station, which is placed about 2,000 yards in rear of the fighting line. Here one or two surgeons, ten men and a cook of the Medical Staff Corps are stationed. This constitutes the *first line of assistance.* From here the wounded are conveyed by rail or road in ambulances to the field hospital, which is placed beyond the range of fire. Here are stationed an ample number of surgeons and members of the Medical Staff Corps. This constitutes *the second line of assistance.* From this point those who are very severely wounded are forwarded to the base or general hospital, and others retained for a temporary time under treatment and sent back to the front. At the general hospital are the superior officers of the Medical Staff and others. Medical Boards are held here, and the wounded are either returned to the front or sent to their homes or a hospital for their future care.

In this lecture I have endeavored to give you as far as I can a fairly correct history of the organization of Hospital and Ambulance Corps, and in the latter part a description of how to handle and treat the wounded on the field. This is partly from my own experience and otherwise, which I hope may be of some use as a guide and help to the inexperienced who may in the future have to undergo the responsibilities in field work in the time of war.

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## PROCEDURE IN POST MORTEM MEDICO-LEGAL EXAMINATIONS.

By CHARLES A. HEBBERT, M.R.C.P., London, F.L.S.,
Lecturer on Anatomy, Faculty of Medicine, University of Bishop's College.

### CASE IV.

The following case is one of presumed abortion, and is of interest as showing one of the difficulties encountered by medical jurists—that of deciding whether the death was due to criminal interference or to natural causes.

The body was that of a female, aged 26 years, 5 ft. 1 in. in height, hair brown, eyes blue, pupils dilated. The body was thin and the eyes sunken in the orbits. Rigor mortis

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was present, and there was some green discolouration of the abdomen and parietes. There were no marks of external violence, and the external organs of generation were intact. A small amount of purulent fluid was escaping from the orifice of the vagina.

The skull was of medium thickness, but showed nothing abnormal.

BRAIN.—There was some injection of the pia mater, and the cerebro-spinal fluid was increased in amount. On section of the brain, the puncta cruenta were marked. The substance was firm and apparently normal.

HEART.—The pericardium was normal. The cavities were distended with black fluid blood, and decolourised clots were found among the musculi papillares. The edges of both tricuspid and mitral valves were fringed with small recent vegetations. The muscular tissue pale.

LUNGS.—There were no adhesions and no excess of fluid in the pleural cavities. The bases of both lungs shewed pneumonic engorgement.

PERITONEUM.—The cavity contained a large amount of purulent fluid. Both the visceral and parietal layers were acutely injected and covered by a layer of fibrinous lymph. This deposit was noticed over spleen, kidneys and liver. The uterus and appendages were also coated by a similar diphtheritic membrane, more especially marked on the anterior surface of the left ovary. It was found on subsequent examination that a cyst of this ovary had ruptured externally, the edges being covered by a thick diphtheritic membrane. This was one of several cysts on the same ovary, the walls of all being lined by pyogenic membrane. The right ovary was shrivelled and atrophied.

The walls of the vagina were somewhat rugose, the mucous membrane soft and swollen, and of a dark red colour, and covered by a muco-purulent discharge. The uterus measured 3½ in. long, 2 in. wide, the body being 2 in. long and cervix 1½ in. The os uteri was eroded, the mucous membrane of the cavity was soft, thick and covered by a blood-stained membranous deposit on its posterior wall, the decidua, adherent to the extent of about 1 in. in diameter

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The fallopian tubes were much distended and filled with pus.

The stomach was normal internally, containing some semi-digested food. The outer surfaces, as the other abdominal organs, showed signs of recent peritonitis. The mucous membrane of the intestine was somewhat swollen and softened and injected.

LIVER.—Enlarged and fatty.

KIDNEYS.—Capsules adherent, cortex diminished, shewing some cysts on the surface; both organs generally congested and dark in colour.

SPLEEN.—Much enlarged and congested.

BLADDER.—The trigonum was injected, but otherwise the walls were normal.

The reason for reporting this case is, as before said, that it is illustrative of one of the most formidable questions to be answered by a medical jurist, involving as it did in this case the liberty of a surgeon. The outside evidence was strong that abortion had been procured, and the post mortem proved that the woman had been pregnant. However, there was no sign of injury to the genital organs, and the death was distinctly due to general peritonitis set up by pelvic peritonitis, caused by the rupture of a cyst of old standing which had became purulent. That the infection had proceeded from the inflammation of the uterus was very probable, and that the inflammation of the uterus was the result of a criminal operation was open to strong suspicion; but, when the question was propounded as to whether it was directly or indirectly the cause of death, the answer had to be an uncertain one, corresponding to the Scotch verdict—Not proven.

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# Selected Article.

## THE HOME TREATMENT OF CONSUMPTION.

By WM. OSLER, M.D.,
Professor of Medicine, Johns Hopkins University, Baltimore.

READ AT THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND AT WESTMINSTER, NOV. 14TH, 1899.

In the city, from the country or from small towns, I not infrequently see persons with pulmonary tuberculosis whose circumstances are such that change of climate or life in a sanitarium is out of the question ; and when we reflect for a moment on the enormous number of cases of phthisis and the trifling accommodation offered in sanitaria, the practical problem whieh confronts us is, how best to treat the 95 per cent. of cases necessarily confined to their homes. Cannot these poor victims reap some benefit from the recent experience of the profession ?

The usual surroundings of a consumptive are only too well known to all of us. In a majority of cases the treatment is desultory, unsystematic and directed to symptoms alone. It is not too sweeping an assertion to say that of the 8,000 or 10,000 cases of consumption in the city of Baltimore to-day, few live under a definite regime. Last spring I saw in rapid succession two cases which impressed upon me forcibly the familiar fact that our theoretical knowledge of this disease has, as is so often the case, not reached a practical working basis. In a small house in South Baltimore I saw a young man, aged eighteen (one of five children), who had had tuberculosis for at least nine months. Nothing could have been more unfavorable than his surroundings, though the people were of the mechanic class, and of good intelligence. The room was stuffy, ill-ventilated, with both windows closely shut, and the temperature of the room, heated by a small stove, was nearly 80°. He had been in bed for at least three months, with much cough and a great deal of expectoration, some of which was visible on the floor, as it did not always reach the spittoon. He had high fever, loss of appetite, and was being fed on panopeptone and beef extracts. The room had a good exposure, and I suggested to the young man to have the bed removed to the window, to be well covered up, and to rest in the sunshine during part of

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every day. The reply was that it would kill him, and I could see by the mother's looks that she was of the same opinion. The doctor, too, I am afraid, regarded me as a fanatic. In the same week I saw a similar picture in a different setting, a young girl who had been in bed for many weeks, with high, irregular fever and a rapidly-progressing disease. I could see that the suggestion of an open-air course of treatment was extremely distasteful, but she was induced to go to the Adirondacks, where she has done very well.

Arrest or cure of tuberculosis is a question entirely of nutrition, and the essential factor is so to improve the resisting forces of the body that the bacilli cannot make further progress, but are so hemmed in that they are either prevented effectually from breaking through the entrenchments, or, in rare cases, they are forced to capitulate and are put to the sword. Of the measures by which the general nutrition of the body may be encouraged and improved, the first and most important is:

*Fresh Air.*—For more than two centuries the clearer-headed members of the profession have known that an open-air life sometimes cures a case of phthisis. One of the earliest and most interesting cases of this kind is reported by John Locke, the philosopher, in his "Anecdota Sydenhamiana." "Mr. Lawrence, Dr. Sydenham's Nephew after a fever fell into a Cough, & other signs of an incipient Phthisis, (the Morbific matter being violently translated in upon his Lungs) and at length the Diarrhœa colliquativa came on: then ye Dr sent him into ye Country on Horseback, (tho he was soe weak yt he could hardly walk) & ordered him to ride 6 or 7 miles ye first day, (wch he did) and to encrease dayly his Iourney as he shd be able, untill he had rid 150 miles: When he had travelld half ye way his Diarrhœa stopt, & at last he came to ye end of his Iourney, & was pretty well (at least somewhat better) & had a good appetite; but when he had staid at his Sister's house some 4 or 5 days his Diarrhœa came on again; the Dr had ordered him not to stay above 2 days at most; for iff they stay before they are recovered this spoils all again; & therefore he betook himself to his riding again, and in 4 days came up to London perfectly cur'd. The same course hath ye Dr. put others upon, especially in Pulmonick Diseases, & wth ye like Success when all things elce had faild him: & he was not ashamed to own yt he was fain to borrow a cure from this way now & then when he found himself puzzled with some lingering Distemper not reducible to a common & known (sic) Disease."

This reminds one of Dr. H. I. Bowditch's description of

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the ride which did him so much good when as a young man he was supposed to have lung trouble.

The quality of the fresh air in our large cities may not be very good, but it is the best a large proportion of our patients can possibly get to breathe, and it is a great deal better than the atmosphere of the overheated, ill-ventilated rooms in which a majority of them live.

I give the following directions: Take the almanac and count off the hours of sunshine. In winter cut off two hours in the morning and an hour in the evening, and for the rest of the day the patient is to be out of doors. If there is no possible arrangement for life out of doors, the patient is to be in a room with a southen exposure with the windows wide open. The bed is to be moved into the sunshine. If there is a balcony or a veranda with a good outlook towards the south, it should be arranged for the patient; if not, a sheltered protection can be put up in the yard at a very moderate cost. On a well-padded lounge, covered with a couple of thick blankets, well wrapped up, the patient sits or reclines all day, coming in only to attend to the calls of nature. Only on blustering, stormy or very rainy days is the patient to remain in the house. No degree of cold is a contraindication. This continuous open-air life, at rest, is the most powerful influence we possess to-day against the fever of tuberculosis. It may take a month, it may take two or even three months before the temperature reaches normal, but it has been one of the many valuable lessons which we have learned from Dr. Trudeau, that in the fever of consumption the patient should not only be out of doors, but at rest, taking no exercise. The bedroom of the patient should be thoroughly ventilated, and the patient should be accustomed gradually to sleep with the window open.

Secondly *Food*.—The stomach controls the situation in pulmonary tuberculosis. In any long series of cases the patients who do well are those who can take plenty of food. An important cause of the lack of appetite and feeble digestion is the persistent fever, and we often find that as the temperature falls the appetite improves. It is easy to lay down rules; very hard to carry them out. Each case must be dealt with separately, but as large a quantity of food as possible should be given. Overfeeding or stuffing, when possible, should be practised, and the patient should be encouraged to pay as little attention to his subjective gastric sensations as possible. We rarely can carry out the autocratic, cast-iron method followed at Nordrach, which insists that a patient who has vomited a meal shall, *nolens volens*, eat another very shortly

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of the same character. For some time I have been urging the patients to accustom themselves to taking raw eggs, beginning with one three times a day, and increasing one a week until they took, if possible, twenty or twenty-four daily. For the hyperalimentation this is probably the simplest and most satisfactory diet. It has been carried out with marked success by Dr. Ely, of Rochester, who literally prescribes eggs by the dozen. Broken into the egg-cup, sprinkled with a little pepper and salt, the egg can be readily swallowed without breaking the yolk. It is most important to get the patient accustomed to taking the natural foods. Milk and cream and butter, meat and eggs and oysters should constitute the main part of the diet.

The medicinal treatment of cases may be divided into—first, the use of stomachics, bitter tonics and certain digestives; secondly, remedies such as codliver oil, hypophosphites and creasote, the benefits of which are chiefly in promoting general nutrition, and, thirdly, remedies for the relief of certain symptoms, as cough, pain, night sweats, etc.

In December last a young woman came to me from one of the towns in the State with well-marked tuberculosis. Her grandmother and two of her father's brothers had died of consumption. She had a cough off and on for three years, and for more than a year she had a great deal of fever, had lost very much in weight and had had profuse night sweats. She never had had any vomiting. When I saw her she had high fever (temperature 103°), and there were signs of extensive disease at the right apex—flattening dullness on percussion with resonant rales as low as the fourth rib. There were signs of involvement of the right apex behind, and there were a few crackling rales at the apex of the lower lobe on the left side behind. She was short of breath, and looked thin and pale. Her weight was 109 pounds. I gave her directions such as I have indicated, and she has given me a brief statement in her own words of her progress in the eleven months. She writes as follows (November 10): "When I begun treatment, the first day I sat out was December 11. 1898; don't know just how cold it was, but could see the river from our porch and they were skating. In winter usually had breakfast about 8 and went outdoors about 9. When I begun was not well enough to walk much, was so short of breath; after sitting out for some weeks would walk up and down porch an hour before sitting down. I spent a good deal of my time reading; became so interested in my book at times forgot how cold it was. The first two weeks I took three eggs a day, one at 10 a.m., another at 3 and an-

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other before going to bed ; then six a day, two at a time, and continued to increase till I got up to fifteen a day ; continued that number for two months or more, then took twelve a day for three months, then nine. For breakfast I had oatmeal and cream and toast, or small piece of beefsteak and coffee ; dinner at 12, drank one glass of milk and ate anything that was on the table in the line of meats or vegetables (provided I liked them) ; seldom if ever eat desserts. Went out immediately after dinner and remained there until sundown ; more eggs at 3 and supper at 6 ; another glass of milk, and with that a small piece of meat, as a rule, and bread. Eggs again at 9, and go to bed between 9 and 10. Was sitting out one day when the thermometer registered 10° below zero. When it felt like snow or rain remained indoors. I kept this up till the weather was warm and then went driving, took eggs along and stayed out in country till dinner time ; drove out again late in the evening, and after my return home would sit out till after 10 o'clock. When I begun treatment had bad cough, expectorated a great deal and no appetite. The cough began to get better, and after about four months I coughed very little ; now, so rarely and expectorate so very seldom that it is hardly worth mentioning. When I consulted you last December weighed 109 pounds ; now tip the scales at 132 pounds. I have improved steadily and gained in flesh gradually from the above date."

This very practical story illustrates what could be done by many patients. Last spring I happened to be in the town in which this girl lived, and I fortunately thought of her and paid her a visit. She lived in a small two-story house, with a narrow balcony on the first story behind, and here at half-past eleven one morning I found her carefully wrapped up. She looked a different girl, and the report indicates that she has done remarkably well. At the time of my visit she was without fever, but there were still numerous moist rales at the right apex.

Since writing the above I have seen this patient (December 1), who looks remarkably well, has a good color, is free from fever, has no cough, no expectoration and weighs 133 pounds. Luckily I dictated a note on the condition of the lung at the time of her first visit, otherwise I should not have believed the extent of the change. The resonance is still impaired, the flattening is marked beneath the right clavicle, the breath sounds are harsh, the expiration prolonged, but there are only a few dry crackling rales on coughing or on deep breathing. There were no signs at the apex of the lower lobe of the left lung behind.

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Two additional points of interest may be mentioned. She has not had a doctor, and she has not had a dose of medicine except an occasional dose of paregoric for the cough. She took creasote for a short time, but afterwards gave it up. shortly before she visited me her physician died, and I did not know, until my visit to her, that she had not been under any professional care. She could not have done better had she been at the Adirondacks under Dr. Trudeau.

A rigid regimen, a life of rules and regulations, a dominant will on the part of the doctor, willing obedience on the part of the patient and friends—these, with the conditions we have discussed, are necessary in the successful treatment of pulmonary tuberculosis.—*Maryland Med. Journal.*

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# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine University of Bishop's College; Physician Western Hospital.

### EARLY RECOGNITION OF PULMONARY TUBERCULOSIS.

KNOPF.* The negative result of the examinations of the sputum has little or no significance, since the tubercle bacilli appear in the expectorations only after disintegration of the tubercles has taken place. The use of Koch's tuberculin as a diagnostic aid is not without its dangers. This procedure sometimes causes an unexpected generalization of the latent disease, with fatal results. The etiology plays quite an important role. Man is more disposed to consumption than woman; the poverty-stricken more than the wealthy; according to some, red-haired individuals more than those having blond, brown or black hair. Vocation, age, heredity, associations, previous ailments, are all important points to be noted in the anamnesis. Coughing spells brought on by a mere change of position, or by an extra respiratory effort, hemorrhages, slight or profuse, persistent elevations of temperature, increased through exercise, loss of weight, are suspicious symptoms. Murat describes, as an early symptom, the recognition on the part of the patient of a vibration of the

* Jour A. M. A., Dec. 9, 1899.

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affected portion of the lung during loud and vigorous talking. Attention must be paid to the upper air passages. Papillon's examinations with the Potain sphygmomanometer showed that an arterial pressure less than 13 cm. frequently indicated incipient tuberculosis. Chief stress is laid upon the physical examination, inspection percussion and auscultation. The agglutination process has not, in the hands of the author, yielded very satisfactory results, though he predicts for it better results upon perfection of the technique.—*Medical Review.*

## LA GRIPPE.

GILCREEST.* La Grippe is a contagious, infectious disease caused by a specific germ first described by Pfeiffer in 1892. The disease is air-borne and propagated mainly through human intercourse, as has been proven by numerous epidemics in prisons, barracks, etc. The pathologic lesions presented by uncomplicated la grippe are of a character common to all infective diseases, *i. e.*, parenchymatous degeneration of various organs. There are three distinct forms of la grippe: 1. Simple without complications. 2. Complicated with serious pulmonary affections. 3. Complicated with digestive and nervous symptoms. The complications are innumerable, including affections of the eye, ear, lungs, pleura, heart, genito-urinary tract, etc. Farson has observed an increase in the number of cases of appendicitis during grip epidemics. The author reports two cases of the severe nervous type, both of which are recovering. We have no specific for la grippe, so that each case must be treated symptomatically with reference to the complication. "To allay pains and soreness and restore free elimination from the skin, kidneys and intestines, are the indications which should guide us in our therapeutic applications."—*Medical Review.*

## A NEW METHOD OF TREATMENT WITH MERCURY.

A. BLASCHKO.† On the theory that mercury, when applied to the skin, finds its way into the organism through the process of inhalation, Blaschko undertakes to reach this end by a specially prepared mercurial preparation, which does not have the disadvantages of the grey salve. The preparation is a sort of cotton cloth, which is impreg-

* Jour. A. M. A., Dec. 9, 1899.

† Berl. klin. Woch., Nov. 13, 1899.

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nated with a 90 per cent. mercurial salve. This is called mercolint. The material is so well prepared that no trace either of the salve or of the mercury can be observed. Shirts are made of this material, which the patient wears next to the skin day and night. When the shirts become white, which takes about four weeks, the mercury has all been absorbed. These garments can be made of varying strength up to 50 per cent. mercury. The author has used this means of giving mercury in his clinic for some time with gratifying results. The advantages of this method over the inunction cure are obvious. Especially is it advantageous in small children and babies, pregnant women, etc. Such shirts can be worn for many months, and would save the patient repeated inunctions cures, with all their discomfort and disadvantages.—*Medical Review.*

## DRY HEAT OF HIGH DEGREE AS A THERAPEUTIC AGENT.

C. E. SKINNER* has employed dry heat, up to 500° F., in the treatment of various diseases. The apparatus used and the exact method of its application are fully described, together with the report of a number of cases showing the mode of procedure in each affection. He has found that hot air is a pain-relieving agent of unequaled value in those conditions where its application is indicated and possible, because of its constant effectiveness, rapidity of action, and the absence of deleterious after-effects. In rheumatism its action is so profound in connection with judiciously chosen drugs that it may almost claim a positive curative power of its own, and may be said to be the most powerful contributory agent we know. It is capable of stimulating tissue repair to a remarkable degree, as is demonstrated by its effect upon sprains. It is capable of influencing most happily septic inflammation of serous membranes, as shown by its action in peritonitis and pleurisy. It will many times at least give us the power of economizing nervous energy by relieving pain and other more or less dangerous conditions in pneumonia, thereby enabling us to refrain from sedatives and cardiac stimulation, and thus save for the patient nervous energy, which will sometimes be sufficient to tide him over a crisis by which he would otherwise be overwhelmed. The addition of hot air to our armamentarium will enable us to increase by a large percentage the sum total of our power over disease.—*Medical Review.*

* N. Y. Med. Jour., Oct. 28, Nov. 25. Dec. 2 and 9, 1899.

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## TREATMENT OF TAPEWORM BY USE OF MORPHINE INJECTED INTO THE PROTRUDING PART OF THE PARASITE.

By J. W. KIME, M.D.,
Editor *Iowa Medical Journal*, Keokuk, Iowa.

The attempt at removal of tapeworm by any of the tænicides is followed by a large number of failures which, by the method which I have used in two recent cases, might be converted into successes.

It is a very common occurrence for the parasite under such circumstances to drop down into the lower part of the intestine and reattach itself with the sacrifice of a considerable portion of its caudal extremity. I have sometimes been able, by copious injections of water or saline solutions, to bring away the head of the worm, but far more requently have I succeeded only in breaking off the worm.

Recently it occurred to me, while attempting to remove one of these pests, fifteen feet of which were visible and ten feet invisible, that I might take advantage of the latter portion by properly medicating the protruding part. I therefore, after tying a string moderately tight around the worm about three inches below the patient, injected above the string, directly into the substance of the worm, one-half grain of morphine; the protruding part was then evered w h scissors just below the ligature, and the three or four inches remaining were passed up through the sphincte
there about ten minutes.

A large injection of water was then given, and the upper portion of the worm passed entirely motionless and apparently dead.

Since reporting this case in the *Iowa Medical Journal* I have treated one other case the same way, and with the same results.

Most varieties of tapeworm have a pair of longitudinal vessels passing from one extremity to the other, through all the segments, and toxic substances injected into the body of the worm are taken up by them and reach every portion of the parasite.

The mistake is often made of simply prescribing some remedy with directions for the patient to use. Only a small percentage of successes can thus be expected.

The only proper method of treating tapeworm is about as follows:

The patient does not fast or have any preparatory treatment whatever, except that he eats no breakfast on the morning of the day of treatment. At about 9 a. m. he is given a dose of infusion of pomegranate, or what is far

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better, of tannate of pelletierine, with one or two drops of croton oil. The patient should be kept at rest, generally under the personal observation of the physician, for two or three hours, when movements of the bowels will most likely occur and the whole or part of the worm be passed. If only a part protrudes, then the hypodermic should be used as above described.

## LACTATION IN A MALE INFANT.

G. M. Blair reports the case of a boy with highly developed mammæ as large as a walnut. Pressure caused milk to exude. The external genitals were normal except that only one testicle appeared in the scrotum. The child's general condition was bad, and he suffered from vomiting and emaciation.

## REMOVAL OF A HAT-PIN FROM THE STOMACH.

J. Halliwell reports the case of a woman, aged sixty years, who accidently swallowed a hat-pin about four and a half inches long. It was removed by abdominal section four days after. Operative details and recovery were without unusual features.

## THE PREVENTION OF HAY FEVER.

Dr. Alexander Rixa, a noted physician of New York, has contributed an article to the Journal of the American Medical Association upon the Prevention of Hay Fever, which just at this time ought to be of much interest to our readers. The practical part of the paper is the prophylactic treatment of the nasal passages of those subject to this recurrent disease. About two weeks before the ordinary time of attack the patient must begin with some antiseptic, and Dr. Dixa believes that Hydrozone, a most inoccuous and powerful germicide, being three volume of peroxide of hydrogen, is best. To begin with he uses in the proportion of 1 to 12 sterilized water, increased to the strength of 1 to 4. In most obstinate cases, when there is still some irritation in the nasal cavity, I give as an adjuvant the following prescription:

℞ Acid borax, gr. xx.
Menthol, gr. iv.
Glyco-thymoline, ʒ ij.
Sol. eucain B. 4 per cent., q. s. ad ʒij.
Sig. Use in atomizer.

As a rule this treatment was sufficient to subvert the disease and keep the patient in comfort.

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# SURGERY.

IN CHARGE OF

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## SOME PRACTICAL NOTES ON DISEASES OF THE RECTUM.

L. H. Adler, jr., refers briefly to some practical points in the consideration of some of the forms of rectal diseases. Congenital malformations of the anus and the rectum occur often enough to justify attention being called to the necessity for every new-born child being carefully examined at the time of its birth. In the treatment of suppurative process in the neighborhood of the rectum, poultices should be avoided and the affected parts laid freely open as soon as the formation of the abscess is recognized, even before pus is present. In all cases of fistula in ano it is to be remembered that the sinus may be the result of a stricture of the rectum, and the usual treatment directed for the relief of the fistula will not result in a cure. A digital examination of the bowel will usually prevent such an error being made. In cases of fistula the internal opening in most cases is to be found between the two sphincter muscles and not higher in the rectum. In the treatment of fissure of the bowel the use of opium should be avoided ; the best remedy is iodoform, preferably in the form of a ten-grain suppository, of which one should be carefully inserted into the rectum half an hour before an expected movement of the bowels and another immediately after the passage has occurred. All hemorrhoids do not require operative interference; in the formative stage frequent ablutions of the part with cold water will allay, if not abort, inflammatory tendencies of the veins, which otherwise finally lead to piles. Operation should not be postponed until the acute inflammation has subsided ; it is when the patient is suffering that consent will be most readily obtained, and it is owing to such advice that patients finally drift into the hands of quacks.—*N. Y. Med. Jour., Medical Review.*

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## FOR THE REMOVAL OF FOREIGN BODIES FROM THE NOSE AND EAR.

Sturrock (*British Medical Journal*, November 25, 1899, p. 1473) recommends the following mode of procedure : The presence and approximate situation of the foreign body having been ascertained, a piece of india-rubber tubing, rather less in diameter than an ordinary lead-pencil, varying in length from one to three inches, and attached to the nozzle of a brass syringe, is introduced into the nostril or meatus, as the case may be, and brought into contact with the foreign body. The piston of the syringe is then pulled out for a sufficient distance to create a vacuum in the tubing, and thus to draw the foreign body into or against its free end. The syringe is then withdrawn and with it the foreign body attached to the tubing. In some cases it has been found advantageous to dip the tubing into glycerin before insertion, in order to diminish the chances of air entering between the tubing and the foreign body.

## DEVICE FOR WASHING OUT THE PELVIS OF THE KIDNEY.

L. B. Tuckerman, in the *Cleveland Medical Gazette* for July, 1899, has devised a simple method of irrigating the pelvis of the kidney. It consists of a No. 6 French catheter, an ounce bulb, and a common exploring aspirator with the ordinary three-way stop-cock, all connected by rubber tubing. The catheter is introduced in the ordinary manner through the Kelley speculum. It is necessary to use a stylet in the catheter, passing the catheter up as far as possible without force, then withdrawing the stylet a couple of inches, passing the catheter farther, and so on, until the pelvis of the kidney is reached ; then by exhausting the contents of the pelvis of the kidney, they can be drawn into the bulb and inspected. From the amount of fluid which is drawn into the bulb we may judge of the capacity of the pelvis of the kidney. If pus, and it be deemed advisable to wash out the kidney, the bulb can be detached from the catheter, filled with boracic acid solution or such other disinfecting fluid as the practitioner may deem best, and, by reconnecting and reversing the stop-cock, the fluid can be injected into the pelvis of the kidney, again withdrawn, until, as in washing other cavities, the fluid comes away clear. To medicate the pelvis of the kidney, the bulb can be filled with the proper quantity of medicament, which in its turn is forced into the pelvis of the kidney where it is left by the withdrawal of the catheter.

This device the author has used recently in the case of

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a woman afflicted with pyelitis, with the right kidney plainly palpable. The right ureter was occluded, or nearly so. In two sittings he succeeded in passing a catheter up to the pelvis of the kidney, and in the third sitting dilated the ureter to No. 8 French. From the pelvis he exhausted an ounce of pus, washed with boracic acid as above described, and filled the cavity with a one-per-cent solution of ichthyol. At the next sitting the ureter was found unobstructed and the capacity of the cavity of the pelvis of the kidney reduced to about three drachms. The patient is a hopeless case so far as a cure is concerned, as microscopic examination of the pus from both ureters shows tubercular bacilli, but she was improved after the washing out of the kidney. In a case of pyelitis of gonococcal origin, it seems rational to treat the pelvis of the kidney by flushing.—*Medicine.*

## GOITRE.

It has been my opinion for some years past that iodine alone was the essential medical remedy for the removal of such goitres as could be influenced by medicine, and with this idea in mind I have, during the last four years, treated three-fifths of my cases with iodine and two-fifths with the thyroid preparation, and have found in thirty thus treated that the patients who received the iodine improved more rapidly than the others, and during the last three months my patients have been taking iodine, only accompanied by tonics as required. Few of them can take iodine steadily for many weeks, without showing evidence of weakness; slight anæmia is likely to follow, with increased rapidity of the heart's action; often slight dyspnœa and headache with diminution of bodily weight. The prescription is as follows:

℞ Iodi (crystals)..... gr. ij.
Pot. iodid ..... gr. iv.
Spir. vini rect..... ʒ i.
Syr. simplicis..... ʒ i.
Aquæ destill..... ʒ ij.

M. S. A teaspoonful in a wineglassful of water one hour after each meal time.

After about two weeks, sometimes from the beginning, an iron tonic is given; and, if the patients are weakening rapidly, strychnine combined with calisaya and iron, the iodine being discontinued for a week or two at a time. After three weeks there is usually a perceptible difference in the size of the goitre. In six months many of the goitres disappear, others are reduced to from one-half to one-eighth their original size. —FREDERICK G. SCHAEFER (*Journal of the American Medical Association*, November 25th).

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## THE EARLY DIAGNOSIS OF TUBERCULAR JOINT DISEASE.

L. W. Ely, in the *Medical Record* of December 16, 1899, says that the late recognition of tubercular disease of a joint is comparatively simple, but an early diagnosis is essential if the case is to be cured with a return of function. In no class of disease does the axiom that the eyes should be used first and most and the hands last in diagnosis apply so well as in these affections. A good history is needed also in arriving at certainty in diagnosis. Tubercular disease is usually characterized by gradual development, and the beginning cannot be, as a rule, definitely fixed. With slight ameliorations it gradually grows more severe ; there is frequently a history of trauma. Pain and stiffness are two important symptoms. Pain is rarely located in a certain spot, but in indicating it the hand is usually passed over a certain region. It is worse on motion, and is apt to come in paroxysms at night, when the muscles holding the joints quiet are relaxed. Stripping the patient is of the utmost importance ; this rule knows no exception in men and children, and in women it should be modified but slightly. Next, the attitude should be observed, then the deformity and change in contour.

The joints most liable to tubercular disease in the order of frequency are the spine, hip, knee, ankle, elbow, wrists, and shoulder. This study is based on 453 cases of tubercular joint disease observed at the Vanderbilt Clinic between January 1, 1895, and January 1, 1899. The history of these cases was negative in 309, in 76 heredity is not mentioned, but in 68 a positive tubercular family history was obtained. Sacroiliac disease, of which much has been written, is very rare ; but one case appears on the record of the Vanderbilt Clinic for four years. The author considers the symptomatology of tuberculosis in the joints.—*Medicine.*

## THE WAYS OF TREATING GONORRHEAL JOINTS.

It will be admitted by most physicians and surgeons that the treatment of gonorrheal joints is most unsatisfactory. The diagnosis is not always clear, but practitioners of experience will generally bear out the assertion that the sudden development of inflammation in a single joint, if accompanied with a urethral discharge, or even if the latter has been for some time suppressed, is sufficient to induce a strong presumption of the specific character of the inflammation. Two lines of treatment seem to offer fair results. One is strictly

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surgical, and consists of immediately opening the synovial membrane under, of course, the most approved antiseptic precautions, allowing the joint to drain, or, if necessary, washing out the joint cavity, providing it is infected. Another is that recommended by Christian Heath, who immediately places such patients in bed, applies belladonna and glycerine freely to the affected joint, and gives quinine in five-grain doses every six hours. He does not use splints, and pays no attention to the urethral discharge.—*Medical Review.*

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# OBSTETRICS.

IN CHARGE OF

H. L. REDDY, M.D., L. R. C. P., London,

Professor of Obstetrics, University of Bishop's College; Physician Accoucheur Women's Hospital; Physician to the Western Hospital.

## PRECOCIOUS MENSTRUATION.

E. Perier mentions a child which began to menstruate regularly at 9 months of age. When seen three months after menstruation commenced, the breasts were well formed, nipples protruding, pubes covered with hair, and labia majora and minora well developed.

## HYPEREMESIS GRAVIDARIUM.

Dirmoser believes that auto-infection from the intestinal tract is the usual cause of hyperemesis, and that the etiological importance of hysteria is largely over-estimated. He refers to the similarity of post mortem changes in hyperemesis and acute infection. Urinary analysis shows an increase of indol, skatol, and other products of retrograde metabolism, also albumin, acetone and peptone. Organic structural elements are found in the urine, indicating a nephritis. There exists an individual predisposition, probably owing to the abnormal condition of the intestinal canal. The best treatment for this obstinate and often serious complication of the pregnant state would be intestinal antisepsis, and the author states that the results obtained from such treatment will be published at a later period.

## AMNIOTIC INFECTION BEFORE RUPTURE OF THE MEMBRANES.

Lehmann reports a case of undoubted infection of the liquor amnii before rupture of the membranes. A thick and extremely fetid fluid escaped as soon as they were artificially punctured.

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## SEPSIS AS A CONTRIBUTORY CAUSE OF PUERPERAL INSANITY.

BRUSH, *American Med. Quarterly*, limits his paper to the consideration of insanity of the puerperium. Numerous statistics show that of cases of insanity in asylums, some six or seven per cent. date from insanity of the puerperal period proper. However, many of these cases come from psychopathic stock, childbirth acting only as an exciting cause. If heredity is one fundamental attribute, Brush appears to believe that sepsis is the other ; that is, whenever hereditary can be excluded, we must look upon the case as having had a septic causation.

Obstetricians of by-gone generations, such as J. Y. Simpson and George T. Elliot, were believers in the toxic origin of puerperal mania, which is not very remote from the idea of sepsis. The most striking document in favor of the sepsis theory is brought forward by Chapin, the alienist, who states that since the introduction of antisepsis in midwifery, there has been an enormous falling off in the number of cases of puerperal mania. A similar falling off has been reported from several insane asylums, although no such decline was observed at the McLean Asylum, in Somerville, Mass. The writer finds that the type of delirium exhibited in most cases of puerperal mania agrees with that form which accompanies intoxications. This is especially true of the early weeks of the disease. A case is given in which the mental symptoms are shown to be rather of the nature of the delirium of acute infectious diseases with its lucid moments, its noisy incoherent ravings, auditory and visual hallucinations, together with the quick pulse, dry, brown tongue, sordes, etc. The condition, however, goes on indefinitely, while always preserving something of the stamp of simple delirium..—*Obstetrics.*

## TRANSMISSION OF STREPTOCOCCUS FROM MOTHER TO THE FETUS.

Bonnaire reports two such cases. In the first the mother was suffering from erysipelas at the fifth month of pregnancy. The membranes had been ruptured three days and putrid liquor amnii was discharging. The fetus was expressed and died forty-eight hours later. Cultures of its blood showed the streptococcus only. In the second case the mother gave birth to a dead child just before she succumbed to cerebro-spinal meningitis. Autopsy showed pus over the cerebral and spinal meningitis, and exactly the same lesion in the fetus. Cultures from both showed streptococci cultures of the blood were negative.

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## TUBERCULOSIS AND PREGNANCY.

Lambinon (*Journ. d'accouchements*, Sept. 24, 1899) gives a brief compilation of the present state of our knowledge of this association. In 1895 Charrin insisted that the toxins in a pregnant woman suffering from an infectious disease would necessarily affect her progeny ; this being especially true of tuberculosis and pneumonia. Children born under these circumstances gain in weight very slowly.

However, the fact has been cited that in orphan and foundling asylums hereditary tuberculosis (which in theory ought to occur more frequently than in children of the living), does not cause an increase in the natural morbidity of childhood in general.

But it is undeniable that now and then a case of undoubted congenital tuberculosis is reported. Lehmann, Doleris, and Bourges and others have published well-attested cases of this sort, explicable by no other hypothesis than intrauterine infection.

Bar and Renon, Schmorl and Birsch and others have found bacilli in the blood of the umbilical vein in cases in which the mother was in a moribund condition from tuberculosis.

Lambinon, however, looks upon such cases as medical curiosities and exceptions which proved the rule. Practically the child of tuberculous ascendants is not exposed to the action of either the bacillus or its toxins. It may inherit a delicate organization, such as would readily fall a prey to tuberculosis, but that is all. A child born of a tuberculous mother should be separated from her immediately after its birth.

## NURSING BY ALBUMINURIC WOMEN.

P. Budin and Chavane have observed five albuminuric women immediately after delivery and four during the months following labor. All of these nursed their children without any unfavorable results to the infants themselves. The albuminuria frequently disappears rapidly, and in any event does not delay convalescence.

## OBSERVATION ABOUT SORE NIPPLES.

According to Platzer sore nipples are caused through biting and pulling, during the process of nursing. The best treatment of fissures are applications of carbolic acid solution. Ulcerations should be washed with corrosive sublimate solution and dusted with dermatol. In mastitis nursing

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must be interrupted, the breast compressed and ice bags applied. Among 1000 nursing puerperæ in Kermarsky's clinic, sore nipples were observed in 51.5 per cent.

## PROPHYLAXIS OF ECLAMPSIA.

Knapp emphasizes the fact that eclampsia appears often in quasi-epidemics—*i. e.*, there are occasions upon which, for some unknown reason, this affection is much more prone to occur than otherwise. Our prophylaxis, however, is restricted to cases which exhibit edema of the eyelids, skin of abdomen, vulva, legs, etc., and in which albuminuria is present. There are certain cases in which these gross features are absent, and in which there is only a persistent malaise ; such cases may lead up to an "eclamptic aura" and convulsions. In the classes just enumerated, then, we have definite prophylactic indications.

But there are other cases in which everything appears to be progressing favorably toward a successful parturition. Suddenly there set in headache, nausea, vomiting and gastralgia. There is a general sense of discomfort, psychical excitability, and a train of nervous symptoms which herald the early appearance of convulsions. To foresee a possibility of eclampsia in cases which are devoid of advance signals, a careful testing of the retina and field of vision should be undertaken.

Broadly speaking the prophylaxis embraces avoidance of psychical disturbances, avoidance of dietetic errors, and protection from exposure. To secure these ends we must insist upon rest in bed (complete), exclusive diet of milk with diuretic waters (lithia), alvine evacuations secured artificially if necessary. To secure diuresis we must be prepared to resort to the salt solution. If there are actual renal lesions, as shown by the presence of marked edema, hot baths and the hot pack are indicated. As eclampsia is synonymous with convulsions we can no longer speak of prophylaxis after the first convulsive seizure has occurred.—*Obstetrics.*

## TREATMENT OF PUERPERAL INFECTION.

A. W. W. Lea draws the following conclusions from a series of 48 cases. A rise of temperature over 101.4 during the puerperium, not obviously accounted for by other causes, should lead to a thorough examination of the genital tract. If no explanation is found, a uterine douche should be at once given. If the temperature falls definitely within twenty four hours, no further explanation is necessary. If, on the other

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hand, the temperature remains high, and the pulse rate has increased, the cavity of the uterus should be explored with a sterile finger. When the initial temperature is great (103 or over) the uterus should be explored at once. When clots or placenta are discovered, they should be removed by the finger or curette, a douche given, and a gauze drain inserted for twenty-four hours. There is no evidence that curettage, if done with every precaution, favors the spread of infection. In a large proportion of cases the infection is rapidly checked. When there is a very virulent infection early curetting affords the best chance of a successful result. If curettage entirely fails, it must be repeated or not, according to the local conditions present. The prognosis, however, is bad. In some cases if curettage fails, and there is no evidence of general peritonitis or infection of the blood, vaginal hysterectomy, if performed in good time, may be successful. Anti-streptococcic serum should be given early and freely in cases of proved streptococci infection. It is of little use in the advanced stages of the disease.

## THE TREATMENT OF THE VOMITING OF PREGNANCY AND PHTHISIS BY OXYGENATED WATER.

Gallois (*Sem. Méd.*) has used oxygenated water in the vomiting of pregnancy for the last three years, and has had only two cases where it failed to cure. This treatment has no effect on ordinary gastric vomiting, but Bonnel has had excellent results with it in the vomiting of tuberculous patients. It is doubtful how it acts; partly, perhaps, by giving up its oxygen, and partly by neutralising the toxic properties of some ptomaine.

## INFLUENCE OF PREGNANCY UPON THE TEETH.

Terrier states that caries is more rapid in its advance, that the sensibility and friability of the teeth are increased, that their chemical composition is altered during pregnancy. These changes are caused by gingivitis of pregnancy, alteration of saliva, acid regurgitations from the stomach, general modifications in the digestive and in the urinary apparatus and increased excitability of the nervous system due to pregnancy. He urges careful cleansing of the teeth and treatment of caries and gingivitis early in pregnancy, while the daily care of the teeth should be continued through pregnancy and lactation.

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# Therapeutic Notes.

## Scarlet Fever.

J. Lewis Smith recommends the following "diaphoretic, diuretic and laxative" mixture for scarlatinal nephritis:

℞ Potassi acetatis
Potassi bicarbonatis
Potassi citratis, āā..... ʒ ii
Infus. tritici repentis. ad..... ℥ viii

A teaspoonful every three or four hours for a child of five years.

Whitla gives the following diaphoretic mixture for the early stages of scarlet fever:

℞ Spiritus ætheris nitrosi..... ʒ ii
Potassi citratis..... ʒ i
Liq. ammon. acet..... ℥ iss
Syrupi simplicis..... ℥ i
Aquæ camphoræ, ad..... ℥ iv

M. Sig. A teaspoonful every three hours.

Widerhofer recommends the following for scarlet fever, with throat affection:

℞ Potassi chloratis..... gr. xx
Syrupi aurantii..... ʒ iii
Decoct. cinchonæ, ad..... ℥ iii

M. Sig. A teaspoonful every two hours.

## Throat Spray.

Whitla uses the following spray for the throat in scarlet fever:

℞ Glycerini boracis..... ʒ iv
Glycerini acid. carbolici..... ℥ iii
Aquæ rosæ, ad..... ℥ x

## Skin Lotion.

J. Lewis Smith recommends the following lotion for the itching of the skin in scarlet fever:

℞ Acidi carbolici..... ʒ i
Tinct. camphoræ..... ℥ ii
Aquæ puræ..... O i

M. Sig. Shake well, and apply over surface when needed for pruritis.—*Jour. Am. Med. Association.*

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TO CURE ITCH IN TWO HOURS.

℞ Sulphur ..... 3 ounces
Quicklime..... 6 ounces
Aquæ..... 2 pints

Boil till combined, then allow to cool and settle; decant and keep hermetically sealed.

Sig. Rub with soft soap for half an hour, then take tepid bath for half hour. Then apply solution and leave on for quarter hour, then take bath.—*Med. Age.*

Dr. Whitla, in the *Therapeutic Review*, says that one of the best combinations in the treatment of baldness consists of:

℞ Pilocarp. hydrochloratis..... gr. v
Otto rosæ..... ♏ viij
Ol. rosmarini..... ʒ iv
Linimenti cantharidis..... ʒ iv
Glycerini puri..... ℥ j
Ol. amygdalæ dulcis..... ℥ ij
Spts. camphoræ..... ℥ iij

M. Sig. To be rubbed well into the scalp, night and morning.

HEBRA'S CORN CURE.

℞ Acid salicylici..... gr. 15
Ext. cannabis indicæ..... gr. 8
Alcoholis..... ♏ 14
Ætheris ..... ♏ 40
Collodii flx..... ♏ 75

M. Sig. Paint on thrice daily for one week; then soak the foot in hot water and pick out the corn.—*Medical Record.*

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# Jottings.

Chloride of sodium is strongly recommended by Perkins, who claims to have used it in every case of ringworm that has come under his observation for the past sixteen years, and in no case did it fail to give relief. In one of these the disease had been of five years' standing, and the cure only took three weeks. The chloride of sodium in fine powder is rubbed up with vaseline to make a moderately stiff oint-

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ment. The affected part, if covered by hair, is shaved, and the ointment is thoroughly rubbed in night and morning. In a few days the part becomes inflamed, after which a simple emolient is applied. Two daily applications of the ointment for three or four days is usually sufficient to destroy the parasite over the area to which it is applied. The simplicity of this method makes it particularly desirable, and it would be interesting to know if other observers reach similar results. There is a possibility that in our search for new and rare chemicals as antiseptics that we are overlooking some efficient and well-known older remedies.

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The following method of treating chlorosis was advocated by Sir Andrew Clark. With careful attention to the diet and a tepid sponge bath, followed by brisk toweling night and morning, he prescribed the following mixture:

| | | |
|---|---|---|
| ℞ | Ferri sulphatis | gr. xxiv. |
| | Magnes. sulphatis | ʒ vj. |
| | Acid. sulph. aromat | ʒ j. |
| | Tinct. zingib | ʒ ij. |
| | Infus. gentian. comp. vel quassiæ q. s. ad. | ℥ viij. |

M. Sig. One-sixth part twice daily, about 11 and 6 o'clock.

Occasionally this acid mixture produces sickness, dries the skin and is otherwise ill-borne. In such cases he prescribed the following alkaline mixture:

| | | |
|---|---|---|
| ℞ | Ferri sulphatis | gr. xxiv. |
| | Sodii bicarb | ʒ ij. |
| | Sodii sulphatis | ʒ vj. |
| | Tinct. zingib | ʒ ij. |
| | Spt. chloroformi | ʒ j. |
| | Infus. quassiæ q. s. ad | ℥ viij. |

M. Sig. One-sixth part twice daily, at 11 and 6 o'clock.

Sometimes neither mixture agrees with the patient, in which case he prescribed sulphate of iron pill with meals, and a saline aperient on first waking in the morning. By this plan Clark held that nine out of ten cases recovered in from one to three months, and by careful attention to the bowels, taking twice a week a pill composed of aloes, myrrh and iron, the recovery probably would be permanent.—*Practitioner.*

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The *Medical Press and Circular* says: "When there is a frequent desire to pass water in elderly or nervous women, or it runs away in the act of coughing, sneezing or laughing, it is generally due to want of power in the vesical sphincter. In such cases the tincture of cantharides will be found of the greatest service if given in small doses of one minim in water three or four times a day."

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INDIRECT CAUSE OF COUGH.—The Charlotte *Medical Journal* gives the timely advice: "Always search well for the cause of a cough. There are frequently cases of chronic cough which have resisted all the usual remedies at the hands of the physician, and which he in desperation practically gives up when he advises the patient to change climate or take a long sea voyage, when, if greater care were taken in searching for the cause by the process of exclusion, he would cure his patient. The relaxed or elongated uvula is a frequent cause. Stringy tenacious mucus hanging from adenoids in the naso-pharynx is a great cause in children. Not infrequently foreign bodies in the external meatus are responsible; this reflex cough is readily demonstrated by passing a probe along the floor of the meatus, which will, as a rule, cause a tickling in the throat. An otitis media discharging pus through the Eustachian tube into the pharynx is not to be lost sight of. Hypertrophy of the lymphoid tissue at the base of the tongue constituting the lingual tonsil when it presses upon the side of the epiglottis or the anterior pillar of the pharynx is a cause of cough not often thought of."

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ENURESIS.—Dr. M. G. Price (*Louisville Jour. Surg. and Med.*) claims to have had much success with this rebellious trouble, and gives below one of the remedies used by him:

| | | |
|---|---|---|
| ℞ | Tinct. belladon ..... | gtt. v |
| | Ext. ergot fluid..... | gtt. x |
| | Tinct. nucis vom..... | gtt. v |

M. Sig. Repeat four times a day.

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BORIC ACID SUGAR FOR THRUSH.—Escherich states that the promptest and most effective method of curing thrush and cleansing the mouth is to put a little boric acid and saccharin on a sterilized rag and give it to the infant to suck.—*Jour. Am. Med. Association.*

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THE
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# Editorial.

## MEDICAL OFFICERS AND THE CANADIAN MILITIA.

The various Infantry Battalions forming the Canadian Active Militia, up to the present time, consist of from four to eight companies, with one or two of ten companies. The strength of the eight company Battalions is in the neighborhood of three hundred and sixty-eight of all ranks; one, however, viz., the 1st Prince of Wales Fusiliers, has an authorised roster of six hundred and sixty eight. These facts at once show that they are all skeleton Battalions, with a compliment of officers sufficient to run it. when made up to its war strength of one thousand men. The regimental system of medical officers has been, and practically is, the one now followed. A Surgeon-Major and a Surgeon-Lieut. or Captain appeared on the strength of each Battalion up to 1894, when Major-General Herbert, in making up the establishment list, dropped the Junior-Surgeon as unnecessary. This action was resented by Commanding Officers, as being injudicious, as it removed an officer who contributed to expenses, which unfortunately are high. When Major-General Gascoigne assumed command of the militia this Junior

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Medical Officer was replaced—but without pay—unless in camp, and then he was to do duty only at alternate camps. There is no doubt that alone, regimental medical officers are inadequate for the duties required during a period of active service in the field. Great Britain found this out during the Crimean War, and the Army Medical Department, now the Royal Army Medical Corps, was the result of this experience. There were, and are, peculiar difficulties to be faced in our Canadian Militia, and though, as we will shortly show, a change will soon come, it will be, and perhaps wisely, in a modified form. To Lieut.-Col. Neilson, Director-General Medical Staff, to which position he was appointed rather more than two years ago from the Royal Canadian Artillery, is due a scheme which has much to commend it. He contemplates forming Bearer Companies at all the large garrison depots, with field hospitals on the line of the British service; also a medical staff. He, however, retains the Senior Surgeon, but removes the Surgeon-Lieut. from the regimental strength, and gives them the option of joining the medical staff, with a rise in rank. All others joining take rank as Lieutenants, with promotion after a stated service. Under ordinary circumstances, such a strength is amply sufficient for all camp duties. The embodiment of the active militia is, however, with a view of having a nucleus ready for augmentation on a declaration of war. Within a few weeks after such a declaration, we should have in the field a force of at least one hundred thousand men or more. For such a force the proposed scheme would, we feel sure, prove utterly inadequate. It may be argued that if war ever takes place in Canada, it will be due to an imperial cause, and, as we would be joined by a large imperial army, so would the direction of medical matters come under the Royal Army Medical Corps. But events in South Africa have proved that this corps is very weak in numbers, and quite inadequate to perform the duties it has been called upon to perform. Forty years ago the British Army and Militia Medical Staff together numbered about 1,350 officers, and at the moment they have sank to under 900. This has been largely brought about by allowing the Militia Regimental

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Surgeons to disappear, by death and age retirement. That process has gone on so steadily that, from a former total of about 250 Militia Regimental Medical Officers, they have sank to a poor remnant of 24, most of them well on in years, and naturally soon to follow their retired brother officers. The result of this condition of things is, now that Britain has made a heavy call on her militia, the Government find themselves without their former Militia Regimental Medical Officers; and with the Army Medical Corps fully occupied, is unable to assign few or any of them to Militia Battalions. The result of this condition of things is, that a host of civilians are being recruited, so to speak, to take their place. A similar state of things exists at the seat of war, where nearly two hundred civilians are now employed. Any one who has had any experience of military life knows that the duties of a Military Medical Officer cannot be learned in a few weeks. Moreover, military medical duties are a species of specialty, and while the civilian medical man is learning them, the corps to which he is attached suffers in no small degree from this want of knowledge. Army officers well know that in any campaign the civilian element becomes a great source of weakness. We readily admit that a unified medical service has conserved force and thereby lessened expenditure, but it would seem as if the theory has been carried to such an extreme in practice as to strike at the root of the efficiency. The present war in South Africa has exposed the evil, and the day of reckoning has arrived. British medical men are loudly clamouring, both for a large increase of the Royal Army Medical Corps and a possible revival of the Regimental Militia Medical Service, or a combination of both. The lesson which we in Canada should draw from the present condition of the British Medical service is, that we should have at our hands, for use when wanted, a large body of medical officers. With this object in view, we would suggest that the Junior Medical Officers of Battalions be not dispensed with. We believe it would be good policy to retain them, while the Bearer Companies, Field Hospitals and Medical Staff be formed as intended, the whole strong enough to perform duty with a force of one hundred thousand men in the field. The

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expense of retaining the Junior Regimental Medical Officer is a mere bagatelle, and should not for one moment be considered when the greater efficiency their presence would ensure is taken into account. In the formation of the Bearer Companies and Field Hospitals, Canada has been too slow. It is now within a month of two years since Director-General Neilson announeed the scheme we have alluded to, and with the exception of at Halifax nothing has been done. The late General Officer commanding the militia, Major-General Hutton, conceived the insane idea of establishing Bearer Companies out of medical students at the various medical schools in Canada. Had he consulted some who could have given him good advice before taking the preliminary steps towards their formation, his scheme would have been spared the inglorious fiasco which met it. Had Director-General Neilson's programme been promptly put into action we might have been able to send one or two Bearer Companies and Field Hospitals to South Africa, where they would have been quite as welcome as are the magnificent fighting material from Canada now there and en route. No contingent from the colonies has done more notable and valuable work than the Bearer Companies and Field Hospitals from Australia.

## THE WAR IN SOUTH AFRICA.

The following extract from the *British Medical Journal* of 24th February, written by Clinton T. Dent, of the Consulting Staff of Surgeons, will be read with much interest:

### Penetrating Wounds of the Head.

Bullet wounds actually penetrating the skull and some portion of its contents are numerous enough, and constitute at first sight the most remarkable cases met with in the military hospitals. First, with regard to the effects on the skull itself: The range will, as is well known and as has been determined experimentally, greatly influence the amount of injury inflicted on the bone. Unfortunately reliable information can very seldom be obtained on this point. All who have read the accounts of the engagements near the Modder River

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and at Colenso will recognise that the men can have had but a vague idea of the range at which they were hit. At Colenso, for instance, scarcely a Boer was seen, and there were tiers upon tiers of entrenched positions. Usually the shortness of the range is much exaggerated; 250 yards is a common estimate. There is no doubt, however, that the Highland Brigade at Magersfontein were shot down at extremely close quarters. Judging by the results of the experiments made with modern small-bore rifles in England and Germany, the bulk of the head injuries seen in hospital have been inflicted at medium ranges, say 400 to 800 yards. This is really what we should expect, for at close quarters the amount of damage caused by a a penetrating wound of the head is so extensive as to be probably fatal.

The more obliquely the bullet enters the skull, the greater will be the amount of damage to the inner tables. If the apertures of exit and entrance are both at a right angle to the plane of the skull, both wounds may seem to be cleanly drilled through the bone, and are scarcely to be distinguished by external inspection. But in all cases the inner table will be more or less broken up at the aperture of entrance; and if the skull is trephined there will be no doubt whatever as to the direction of the wound. Even in a long wound fragments of bone may be found lying along the greater part of the track. In not a few instances where trephining has been done at the front a second operation has been found necessary at the base, and much loose bone removed.

At very short ranges the skull may be burst open to a greater or less extent in the manner which has been shown experimentally to take place. Thus in Colonel Stevenson's work on *Gunshot Wounds* a skull is figured into which a small-bore bullet had been fired at a distance of few yards. I have not the work by me for reference, but believe the distance was ten yards. The skull is seen to be most extensively fractured. The specimen is in the Museum at Netley to the best of my recollection.

The observations made above relate to the calvarium, and instances may now be cited bearing out the foregoing remarks. I have to thank the surgeons for permission to give the following sketches of the cases under their charge. Frequently the patients as they are moved from field to base hospital or on to hospital ships have been under the care of several surgeons, and it is impossible to communicate with all. Moreover often—too often indeed—the patients are shifted about in the base hospitals, and it is far from easy to follow out a particular case without giving much trouble to the much over-

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worked administrative staff. The following are examples of injury at close range :

Private D., wounded at Modder River on December 10th, 1899. Entrance wound 2½ inches behind right parietal eminence in a line drawn between that eminence and occipital protuberance. Exit through frontal bone in right side close to longitudinal sinus. The bullet traversed at least 6 inches of brain tissue. The left arm was completely, and the left leg partially, paralysed. There was evidence of fracture of the base on both sides. Sanious discharge from both ears and deafness. The fissure seemed to split the skull in two in the vertical plane. A large flap connecting the two bone wounds was turned down and the skull trephined on the inner side of both the exit and entrance wounds. Many fragments of bone were removed from dura mater, and also blood clot and damaged brain matter. The scalp wound united at once, save over the anterior crown of trephine, where it was healing by granulation (on December 27th), and where there seemed to be some tendency to hernia cerebri. The deafness improved rapidly, and the discharge from the ears, at first abundant, soon ceased. On December 27th he could hear well ; no facial paralysis. The leg had recovered power to a very considerable extent, but, as usually happens, the footdrop was almost complete. The arm was still completely paralysed. His memory and mental condition generally were practically normal. Recovery seemed probable. Further notes of this case are promised. Probably the cortex was not damaged by the fragments of bone, but the motor areas of the arm and leg were damaged by the track of the bullet passing close beneath the cortex.

In another case of wound at undoubted short range the bullet entered close to the longitudinal sinus in the occipital vein, possibly even wounding it, and passing out through the frontal bone, traversing several inches of brain matter. The skull was trephined in front of the posterior wound, and it was found that a fissure connected the apertures of entrance and exit. Fragments of bone were removed and brain matter. Free hæmorrhage necessitated plugging the wound posteriorly, but it was not certain that the hæmorrhage came from the longitudinal sinus. Forty-eight hours later the bleeding recurred on the removal of the plug, and it was replaced. Thenceforward rapid recovery. The wound was received on December 15th, and a month later the power had almost entirely returned in the arm and to a great extent in the leg, but there was still marked footdrop. The mental condition was altogether satisfactory.

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## THE APPENDICITIS QUESTION AGAIN.

The *New York Medical Review* of December 30, 1899, says:

"To operate, or not to operate, in appendicitis" is still one of the absorbing questions of the hour. The physician proper still leans favorably to the expectant plan of treatment, while the operator urges removal of the appendix in all cases as being the only method of cure. The surgeon, however, weighs the pros and cons for operation in each case, and governs his action accordingly. Of course each patient, and every attack of appendicitis, must be considered as an entity, and no steadfast rules can be set down to govern all cases. Certain clinical facts have been demonstrated so often in the course of this affection that broad lines of action may be formulated upon them. Briefly stated these are as follows:

1. As we can never tell from the nature of a previous attack of appendicitis what will be the character of the next seizure, or when, if ever, it will occur, a patient who has had one mild attack should have this clinical observation clearly stated to him, and the decision for or against operation left with him. If a patient has had more than one attack, the probability of a recurrence is much stronger, and the surgeon may even urge an operation in the interval, the burden of responsibility, in case of refusal, being placed upon the shoulders of the patient. Under this head belong all those cases in which, after the subsidence of the acute seizure, the parts apparently return to their normal condition. Should adhesions of the appendix to neighboring structures have occurred, which in themselves cause pain and interference with the general well-being of the individual, there would exist a further indication for surgical interference.

2. If, during the course of an acute inflammation of the appendix, there is manifested a distinct tendency to a regression, we may safely wait for the subsidence of the attack, and then consider the patient as outlined above. Such regression is determined by careful observation of the triad of symptoms, which in relative importance are: (*a*) Pulse

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rate ; (*b*) local pain and rigidity of the abdominal muscles ; (*c*) temperature elevation. If the pulse rate steadily declines and the other two symptoms become less marked, the inflammation is regressing, and operative attack can be deferred.

3. But if there is a distinct progression as indicated by an increasing rapidity of the pulse, and more marked local pain and rigidity, irrespective of temperature elevation, operation is urgently demanded.

4. Abscess cavities call for immediate careful evacuation.

5. General peritonitis demands immediate operative interference, except when the general condition of the patient forbids a formidable procedure. Such latter patients do better if treated expectantly, and often enough these desperate cases improve, and then their subsequent surgical treatment depends upon the local condition.

These general principles of action will be found to govern the vast majority of cases. But one must never forget that appendicitis does not always run a typical course, and in the atypical cases the internist and the surgeon both must rely on their past experiences to enable them to decide for or against operation.

## FIRST INTERNATIONAL CONGRESS OF MEDICAL DEONTOLOGY OR MEDICAL ETHICS.

This Congress will assemble on July 23rd next in Paris. The first meeting will be held at the Palace of Congresses and Social Economy, situated within the Exhibition grounds. Subsequent meetings will be held at the Faculty of Medicine, 12 Rue de l'Ecole de Medicine, Boulevard St Germain. The Congress will continue one week. It is divided into four sections, before which will be discussed all or practically all subjects which pertain to the Congress. Great Britain is taking an active interest in this meeting. Canada has, of late years, taken but little interest in what we may term "Medical politeness," but it is hoped that Canadians, who propose to be at the main International Congress in the first week in August, will reach Paris in time to attend the one on Ethics. Their presence would enable them to learn how this subject is viewed by British and continental medi-

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cal men. If the views which may be promulgated meet with their endorsement they subsequently might be presented for adoption by our various Canadian Medical Societies. Certainly the subject is one which commends itself to the older members of the profession, especially in our larger cities, where now-a-days medical ethics is rarely heard of, and but little acted upon. The managers in Paris are making every endeavor to arrange for the comfort of those attending, and the Secretary has sent out circulars recommending agencies. These undertake for very moderate prices to obtain rooms in advance, from 6 francs per day up, and to meet the member of the Congress at the station on arrival, look after the transport of the baggage to the lodgings, afford interpreters and so on. Such, for example, are the Agence Desroches, 21 Rue du Faubourg Montmartre ; La Société des Voyages Duchemin, 20 Rue de Grammont ; Voyages Pratiques, 9 Rue de Rome and the Voyages Modernes, Rue de L'Echelle, No. 1, Paris. All these different agencies are strongly recommended by the officials of the Congress.

Dr. J. G. Adami, of Montreal, is the member for Canada of what is called "The Committee of Patronage."

## THE MINISTER OF MILITIA.

It must be a source of pride to all Canadian Medical men that a medical man—the Hon. Dr. Borden—who is Minister of Militia, has proved so efficient in the working of his department, in connection with the various contingents which Canada has sent to the war in South Africa. Few could have done as well, and certainly none better. The first contingent, collected as representative of our Militia from the Pacific to the Atlantic Ocean, sailed from Quebec fourteen days from the date of the issue of the first order for its formation. We can form an idea—from this promptness—how hard the Minister must have worked, and how ready for an emergency is his department. We hope to, in time, see some official recognition of this work. In the meantime, he may be assured that the country and medical profession recognize the splendid work he has done.

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Dr. Mayrand, of St. Andrew's, died early in March at an advanced age. He graduated from McGill College in 1847. He was for many years the Surgeon of the 11th Batt. (Argenteuil Rangers), and never missed going to camp with it, where he often filled the position of Principal Medical Officer. He retired in 1898 with the rank of Lieut.-Colonel. Dr. Mayrand was an enthusiastic loyalist and militia officer. He was a most genial companion, and was beloved by all who knew him.

Dr. Albert Edward Senkler died at his home in St. Paul, Minnesota, on the 10th of December. He graduated at McGill University in 1863. He was a native of Brockville, Ont., where the interment took place.

The *British Medical Journal* of January 24 says: "We are informed that there is a movement on foot in Edinburgh which has for its object to procure for Dr. Osler, Professor of Medicine in Johns Hopkins University, Baltimore, a call to the chair of the Practice of Physic in the University of Edinburgh rendered vacant by the death of Sir Grainger Stewart."

Her Majesty the Queen has conferred the honor of Knighthood upon Dr. Thomas Lauder Brunton, F. R. S.

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## PERSONALS.

Dr. William Osler (M.D., McGill, 1872) has been elected an Honorary Member of the Royal Academy of Medicine of Ireland.

Dr. F. R. Wainwright (M.D., McGill, 1898), and lately one of the Resident Medical Staff of the Montreal General Hospital, has left Charlotte, North Carolina, and gone to England, with a view of entering on practice there.

Dr. Norry Worthington, of Sherbrooke, has gone to South Africa as Surgeon of C Battery, Royal Canadian Artillery.

Dr. Keenan, M.D., McGill, 1898, and lately one of the House Staff of the Royal Victoria Hospital, has been appointed Surgeon of the Strathcona Horse, and sailed with it for South Africa on the 17th March.

Dr. Sutherland (M.D., Bishop's, 1899), late House Surgeon Western Hospital, has left for Great Falls, Montana, to act as Assistant to Dr. Longeway (M.D., Bishop's, 1886.)

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# Book Reviews.

**Histology and Pathology.** By John B. Nichols, M.D., Demonstrator of Histology, Medical Department Columbian University, and F. P. Vale, M.D., Assistant in Pathology, Medical Department University of Georgetown, Washington, D.C. In one handsome 12mo. volume of 452 pages, with 213 illustrations. Cloth, $1.75 *net*. Flexible red leather, $2.25 *net*. Lea Bros. & Co., Philadelphia and New York.

This work is the newest of Messrs. Lea's excellent series of pocket text-books, and illustrates the growing tendency to break down the barrier between student and practitioner. Text-books used to be written for students alone, for practitioners were supposed to be done with books forever.

Another valuable principle recognized in this work is that pathology, for the most part, is only histology gone astray. The two are here included between one set of covers in a moderate compass of less than five hundred small and well printed pages, and all very attractive to the eye and to the hand.

No attempt is made to explain in words what can only be learned in the doing, that is to say the book is not "practical," because no book can be practical since practice is an affair of the hand. It does contain, however, in a convenient form a good statement of the observations and results acquired by hand-workers in both of these subjects, indeed everything which it is lawful for a student or practitioner to know. Nor are the higher problems in pathology left untouched, for there is interesting mention made of fever, immunity, susceptibility and other phenomena of a like obscure nature.

The authors, Dr. Nichols and Dr. Vale, set for themselves a definite task to present the essential facts of histology and pathology in a concise and systematic way. They have insisted upon arrangement and convenience more than upon originality, and laying aside disputed doctrines in pathology they have succeeded in presenting these two subjects in a concise and attractive way to those who may require to learn them for the first time, or who may afterwards desire to refresh the memory.

An illustration which illustrates nothing is of no value; if it misrepresents, it had better be omitted. Many of the illustrations fall in one or other of these classes. Some of the photographic reproductions, especially of the nervous system, are as meaningless as those in an English medical journal, and many of the drawings, such as those of the intestinal ulcerations, take up much space with no adequate benefit. The drawings and diagrams in the histology section are really illustrative and illuminating. Last of all, the book being designed for the pocket, it would be in harmony with this design if the thirty-one pages of catalogue at the end were given up to something more immediately useful than a list of Messrs. Lea's publications, excellent as all these publications are.

A. M.

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**Operative Surgery.**—By Joseph D. Bryant, M.D., Professor of the Principles and Practice of Surgery, Operative and Clinical Surgery, University and Bellevue Hospital Medical College; Visiting Surgeon to Bellevue and St. Vincent's Hospital; Consulting Surgeon to the Hospital for Ruptured and Crippled, Woman's Hospital, and Manhattan State Hospital for the Insanef Vol. I. Seven Hundred and Forty Nine Illustrations, Fifty o. which are Colored. New York, D. Appleton and Company, 1899. Price $5.00, Cloth. Sold by subscription.

This volume is a more than ordinarily excellent one. The reviewer has for years used the second edition as a constant work of reference, and has for some time been looking forward to the appearance of the present (third) edition, which the author has entirely recast so that it would conform to the Surgery of to-day. While the second edition, at the time of its publication, was unexcelled, the third, now to hand, is in every way superior to it.

The author's experience of twenty years' teaching of anatomy and surgery is presented to the reader in such an explicit style that the perusal of the various chapters is most pleasing, and in no sense wearisome. The rapid strides made by Surgery in the last few years has compelled the author to enlarge the work, thus necessitating the issuing of two volumes instead of one, as formerly. This fact proves that the various subjects have been fully covered. The subjects considered in this volume include general principles, anæsthetics, antiseptics, control of hemorrhage, treatment of operation, wounds, ligature of arteries, operations on veins, capillaries, nervous system, tendons, ligaments, fasciæ, muscles, bursæ and bones, amputations, deformities, and plastic surgery.

Everything is simplified and rendered clear; details are well explained, and technique is thoroughly elucidated, thus making the comprehension of operative surgery a comparatively easy matter. One of the special features of this work is the very thorough manner in which it has been illustrated, many of the figures being colored. This renders great service in making it possible to, with ease, mentally grasp and fix the details of the many and complicated operations. Taken altogether the work will prove invaluable as an instructor to the student and a reliable guide to the operating surgeon. The printing, paper, binding and execution of the illustrations are of the best. We predict for the work a large sale.

R. C.

**Essentials of Diseases of the Skin.** By Henry W. Stelwagon, M.D. W. B. Saunders, Philadelphia. J. A. Carveth & Co., Toronto.

The growing importance of skin diseases is well known, and the arrangement in this book of questions and answers is of great value to both practitioner and student; more so to the latter, as it is of great help to those going in for examination on the subject.

The illustrations are very good, and the work has been carefully prepared and fulfils the intention of its author.

J. M. J.

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**The International Text Book of Surgery.** By American and British authors. Edited by J. Collins Warren, M.D., LL D., and A. Pearce Gould, M.D., F.R.C.S. Publishers, W. B. Saunders, Philadelphia. J. A. Carveth & Co., Toronto, Ont.

The first volume of this splendid work, devoted chiefly to general surgery, is certainly a credit to the editors, and again demonstrates that the ever-widening field of surgery is best treated by several authors. The body of the text is in large clear type, supplemented by numerous short paragraphs in smaller type where the subject matter is not so important—an excellent system enabling the reader to review a subject more rapidly. The illustrations and colored plates are numerous and good. The treatment of the various subjects is essentially modern, and antiquated theories and methods are not rehearsed to the detriment of the more satisfactory ones of to-day. The chapter on the technic of aseptic surgery is very good, showing as it does the reaction from unnecessarily elaborate methods to a simple yet most complete method. The treatment of each malady is very fully considered and must be most helpful. It is a work equally beneficial to student and practitioner as a complete modern reference work.

G. F.

**A Practical Treatise on Materia Medica and Therapeutics.** By Roberts Bartholow, M.A., M.D., LL.D. Pp. 866. D. Appleton & Co., New York, 1899. Tenth edition, revised and enlarged.

Of Bartholow's work, which has been before the profession now for twenty-three years, there is little new to say. The author, as evidenced by this tenth revised edition, still writes as clearly and succinctly as ever. To one reading the volume for the first time, it is a marvel of compactness and completeness, with a welcome absence of discussion, which, valuable as it may be to the advanced pharmacologist, is irritating and confusing to a student and unsatisfactory to the general practitioner. It is essentially a practical work. Of the classification nothing need be said, it is practical; and as no classification of drugs that is practical is perfect, or being perfect is practical, it is perhaps as good as any, although Cushny's, of Michigan, based on that of Buchheim and Schmiedeberg, of Strassburg, is perhaps preferable. The section on alimentation is excellent, and brief enough to be easily carried. Its vast importance merits its position in the book. An extended review is impossible with the space at my disposal, but I am rather surprised to see the chloride of iron and chlorate of potassium treatment still retained for diphtheria, while the subject of antitoxmes is dismissed with three pages, and the statement that 'a candid survey of the whole field constrains him to say that the practical outcome is short of the success which seemed warranted by the pretentions put forward by the original promoters.' If this refers to the whole field of diseases known to be of microbic origin, the statement is, in our present stage of experiment, unfortunately largely true, but the brilliant results in two or three diseases augur well for ultimate success in others. Coming from a recognized

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authority it is apt to convey a wrong impression to the student, and I should be sorry to think that the labours of a Schaefer, Roux, Pasteur, Ehrlich, Koch, von Rüch and others had reached their limit. A noticeable feature, which, while I do not think commendable, will be found very useful by the commencing practioner, is the frequency with which prescriptions are met with all through the book. Under the heading Electricity—Public Supply—the author mentions two forms of current available from public mains—the arc and incandescent; this is probably a slip, as the terms refer to the style of lamp and not the current—what was meant probably was the alternating and direct current. The former is now used almost exclusively for both arc and incandescent lighting, motor work, galvano-cautery, etc. There is no mention of the sinusoidal current.

Altogether, the book is a valuable aid to the study of an intricate, intensely interesting, but much neglected subject. The printing and binding are in the Appletons' usually perfect style, but why do the ophthalmologists not rise up in their wrath and insist on a dull-finished paper with a uniform black type, instead of the polished reflecting surface with spider type that is at present ruining the eyesight of thousands of readers? R. W.

**Annual and Analytical Cyclopaedia of Practical Medicine.** By Charles E. de M. Sajous, M.D., and one hundred associate editors, assisted by corresponding editors, collaborators and correspondents. Illustrated with chromo-lithographs and maps. Volume IV. The F. A. Davis Co., Publishers, Philadelphia, New York, Chicago, 1899.

This *Annual*, we may again inform our readers, is arranged on a plan quite different from anything heretofore issued. It will be complete only in six volumes, two of which are coming out annually. All the matter is arranged alphabetically, so that it is a work to consult on any specific point rather than for the reading of the diseases of any particular class or system. Thus, diseases of the nervous system will be found scattered all through the six volumes, and covering a period of three years before the subject will be dealt with in full. When complete it will be a valuable work of reference, as the articles are very exhaustive and well written. Among the hundred sub-editors are the names of the best writers in Europe and America, which insures reliable and authoritative treatment of the various subjects.

The text proper is printed in large type, and references from the literature of the last 4 or 5 years is interspersed in smaller type. Numerous and well-executed illustrations, coloured and otherwise, add to the usefulness of the *Annual*.

Besides this volume a monthly journal is issued to subscribers, which keeps the reader abreast of all recent progress, and these bound, become valuable additions as references to the regular volumes. We learn with pleasure that this *Annual* is receiving warm approbation and extensive support from the profession. It will prove a valuable book of reference for writers, teachers and practitioners. J. B. McC.

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**The Nervous System and its Constituent Neurons.**—Designed for the use of practitioners of Medicine and of students of Medicine and Psychology. By Lewellys F. Barker, M.B., Tor., Associate Professor of Anatomy in the Johns Hopkins University and Assistant Resident Pathologist to the Johns Hopkins Hospital. With two colored plates and six hundred and seventy-six illustrations in the text. New York, D. Appleton & Co., 1899.

This is undoubtedly one of the most valuable contributions to neurology which has appeared during the century, containing as it does all the recent advances, sifted and comprehensively arranged, in one neat volume, covering some eleven hundred pages Readers of the New York Medical Journal will be familiar with some of the contents of this work, notably the introductory chapters. These articles appeared at intervals during two years from 1897. The bulk of the book, however, is new material. "In the first part of the volume the newer conceptions of the histology of the central and peripheral nervous organs are reviewed. In the succeeding chapters the attempt has been made to apply the neuron conception —that is the cell doctrine—as consistently as possible in the explanation and description of the complex architectonics of the nervous system."

The subject matter is included in six sections. The first five cover some three hundred pages, and include the history of the development of the neuron conception, giving the work of His, Golgi Farel, Ramon J. Cajal and others; the vital staining of nerve elements, etc.

The external and internal forms of neurons and their histogenetic relation and the neurons as the unit in physiological and pathological processes are discussed in the second to fourth sections, The bulk of the book, some 800 pages, is devoted to a consideration of the grouping and chaining together of neurons in a complex nervous system like that of man and mammals. In this section there are five subsections: first, neurons connecting the sense organs of the body with the central nervous system; the neurons within the central nervous system connecting the end station of the axones of the peripheral centripetal neurons with other portions of the central nervous system and neurons which in turn connect the end station of the latter with still higher portions of the central system; neurons connecting the central nervous system with the voluntary muscles of the body; neurons within the central nervous system which enter into conductive relation with the lower motor neurons and throw the latter under the influence of other centres, Projection commissural and association neurons of the telencephalon. One can gain an idea of the scope of the work from the above headings.

In these chapters an immense amount of work by numerous investigators is represented which the author has introduced with his own, and arranged and classified it so that an intelligent conception can be gained of the complicated distribution of the nerve fibres throughout the body. To better understand the descriptions,

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the work is profusely illustrated by original drawings and selections from various sources.

Great credit is due both author and publishers for the excellence represented in the printing, illustrations and scientific presentation of an interesting but abstruse department of medical research. The book must have a great influence in promoting a more widespread interest and giving information otherwise difficult to obtain in regard to the latest developments of neurology.

J. B. McC.

**Manual of the Practice of Medicine**—Prepared especially for students, by A. A. Stevens, A.M., M.D., professor of Pathology in the Woman's Medical College of Pennsylvania. Instructor in Physical Diagnosis in the University of Pennsylvania. Fifth Edition, revised and enlarged. Illustrated. Price $2.00. W. B. Saunders, 925 Walnut St., publisher. Canadian agents, J. A. Carveth & Co., Toronto, Canada.

In the multiplicity of the calls made on the medical student of the present day, ponderous Text-Books cannot occupy the place they did a decade ago. In Medicine as well as in Surgery there is much that can be boiled down, the theoretical, largely giving way to the practical. Nowhere can this be better learned than in the out-patient department of a hospital, where the practical part of medicine is ever in evidence. The author of this little manual is an out-patient physician to the Episcopal Hospital. He is, therefore, in our opinion well qualified to write a concise and practical manual. The proof of his qualification is the little volume which we most heartily commend to medical students.

F. W. C.

**Braithwaite's Retrospect of Medicine.** A half-yearly journal, containing a retrospective view of every discovery and practical improvements of the medical sciences. Volume 120, July-December, 1899, issued January, 1900. London, Simpkin, Marshall, Hamilton, Kent & Co., Limited.

We have to thank the publishers for a copy of this journal, which courtesy we quite appreciate. When we began our professional career nearly forty years ago, *Braithwaite's Retrospect* was a standard publication, to be seen on the study table of all who desired to be *au courant* in medical matters. It is the same to-day, and fills a position not occupied by any other.

F. W. C.

**Christian Science.** An exposition of Mrs. Eddy's wonderful discovery, including its legal aspect, a plea for sick children and other helpless sick. By William A. Purrington, Lecturer in the University and Bellevue Hospital Medical College. New York: E. B. Treat, 241-243 West 23rd Street, 1900. Price $1.00.

Of all modern fads, none has, perhaps, attracted more attention, or gained greater headway, up to a very recent period, than that known as "Christian Science." The utter absurdity of many of

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their claims has drawn attention to the general system, which has been flooded with light. The result must be a natural death within a very short time. In this beneficial work the volume before us will play an important part, for it is a thorough *exposé* of Mrs. Eddy's claims. That this expose is necessary is clearly proven by Mr. Purrington's book, which we commend to all those desirous of posting themselves on this matter. F. W. C.

**A Text-Book of Diseases of Women.**—By Charles B. Penrose, M.D., Ph.D., Professor of Gynecology in the University of Pennsylvania; Surgeon to the Gynecean Hospital, Philadelphia. Illustrated. Third edition revised. Philadelphia: W. B. Saunders, 925 Walnut street, 1900. Price $3.75.

In the introduction the author says: "I have written this book for the medical student. I have attempted to present the best teaching of modern gynecology untrammelled by antiquated theories or methods of treatment. I have in most instances recommended but one plan of treatment for each disease, hoping in this way to avoid confusing the student or the physician who consults the book for practical guidance. I have, as a rule, omitted all facts of anatomy, physiology and pathology which may be found in the general text-books upon these subjects. Such facts have been mentioned in detail only when it seemed important for the elucidation of the subject, or when there were certain points in the pathology that were peculiar to the diseases under consideration." A careful perusal of the work, which embraces 531 pages, shows that the author has succeeded admirably in his endeavor. It possesses three qualities: completeness, conciseness and clearness. In the forty-three chapters everything has been thought of; nothing has been left out. There is a whole chapter for instance on cancer of the cervix, another on gonorrhœa in women, and another on the menopause; the last chapter treats exclusively with "the effect of the removal of the uterine appendages." Gynecology is making such rapid strides that any book which is more than two or three years old is out of date unless it has been revised. Dr. Penrose realizes this, and has thoroughly revised it since it first appeared some three years ago. This is especially important on account of the changes in treatment, which is constantly improving; those who consult this work will find that the advice given is in accordance with the opinions held by the leading gynecologists of the day. It is hardly within the province of a brief notice of the book to refer at length to any of the opinions expressed by the author. But this much we may say: that we wish every practitioner would read the chapters on lacerations of the cervix and cancer of the cervix, and on hemorrhage at the menopause. We feel sure that by so doing they might contribute very considerably towards stamping out cancer of the cervix altogether. The chapters on the early operation for tubal pregnancy and ovarian cysts are also very convincing as well as important. Many other important points might be noticed, but want of space prevents us particularizing further. The book should be in the hands of every student and practitioner.

A. L. S.

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# PUBLISHERS DEPARTMENT.

## LITERARY NOTES.

*The Living Age* announces a four-part story, called "Misunderstandings," translated from the French of Madame Blanc, to begin in the number for March 3. The "misunderstandings" referred to arise from the free and unconventional conduct of an American girl in Paris, and the story is, in effect, a new "Daisy Miller" from the Parisian point of view.

Sir Walter Besant comes to the defense of Mr. Kipling from the furious assault latety made upon him by Robert Buchanan, in an article entitled "Is it the Voice of the Hooligan?" which *The Living Age* for Feb. 17 reprints from the Contemporary Review.

Mr. J. Cuthbert Hadden's article on "The Tinkering of Hymns" in *The Living Age* for Feb. 24 will strike a responsive chord in the hearts of all who object to the mutilation of the classics of hymnology.

An article on The Intellectual Future of Japan, in *The Living Age* for March 3, derives interest from the fact that it is the view of a native Japanese, reprinted from a Japanese magazine.

The leading article in *The Living Age* for Feb. 24 is a thoughtful and discriminating review of Socialism in the United States from the Nineteenth Century.

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CANADA
MEDICAL RECORD

APRIL, 1900

# Original Communications.

## GYNECOLOGICAL NOTES.

By A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., England.
Fellow of the British and American Gynecological Societies; Professor of Clinical Gynecology in Bishop's University; Gynecologist to the Montreal Dispensary; Surgeon-in-Chief of the Samaritan Hospital for Women; Surgeon to the Western Hospital, Montreal.

*Abdominal Tumors Complicating Pregnancy.*—Several articles have lately appeared on this subject. The question being discussed is this: When an abdominal tumor is discovered during pregnancy, what course should we adopt towards it? This will depend very much upon whether the tumor is giving any trouble or whether it is likely to do so before labor shall have been ended; also, whether the tumor is an ovarian or a fibroid one; and again, whether, if a fibroid, it is interstitial or pedunculated. I have been called quite frequently to advise in each of these cases, and I have found the following procedure to be the best: In all cases of ovarian tumor an operation should be performed at once for two reasons: First, because it is no more dangerous to remove the tumor during pregnancy than at any other time; as a rule its removal has not been followed by a miscarriage, and the patients made excellent recoveries, none having died. And, secondly, because every day that an ovarian tumor remains in the abdomen the woman is running the risk of losing her life, not only by the mere growth of the tumor, but by what is far more serious, namely, from the complications, twisting of the pedicle, hemorrhage into the cyst and the formation of adhesions to the intestines. As a rule, ovarian cysts grow very rapidly during pregnancy on account of the

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increased blood supply, and if the tumor, which is discovered early in pregnancy, is allowed to remain until labor is over, it will have increased enormously in size, in addition to the above mentioned dangers. Moreover, if the ovarian tumor is locked in the pelvis, it would be most serious to leave it there, as it would render natural delivery impossible.

With regard to fibroids, if they are causing no severe symptoms, I prefer to wait until a few months after delivery, and then, if the tumor is causing hemorrhage, to perform hysterectomy. Sometimes, however, they cause considerable pain. In one case to which I was called by Dr. McNamara, the tumor was a sub-peritoneal one, and had caused very little pain until the end of the third month, when it rose with the uterus out of the pelvis and took a rapid growth. It caused so much suffering that I decided to remove it, which was easily done by making a rather long abdominal incision and lifting the pregnant uterus and tumor out of the abdomen and laying them on a sterilized towel. The pedicle, about 3 inches wide, was clamped close to the uterus, and the tumor, the size of a small cocoanut, was removed. The stump was closed with interrupted silk stitches, and the clamps were removed. The bleeding was furious for an instant until they were put on again, and another row of medium silk stitches were applied. On removing the clamps the second time there was only a little oozing, which was completely controlled by a third row of fine sutures. The uterus was replaced, the incision closed, and the patient made an easy recovery, and went on to full time, and had a normal labor.

In another case of fibroid during pregnancy to which I was called by Dr. T. F. Wilson, it seemed almost impossible that the woman could be delivered by the natural channel on account of the size of the tumor and its location in the lower segment of the uterus. I was loth to operate, having been very much impressed by a similar case reported by Dr. Weeks, of Portland, at the Washington International Congress, in which a miscarriage was induced about the fifth month, and the patient died from uncontrollable hemorrhage. Sir William Hingston was also called in consultation, and, as he was strongly opposed to interfering, we decided to wait

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until labor began, and then to operate if necessary. In due time labor came on, and little by little the tumor was drawn up out of the pelvis allowing the head to engage, and the woman was delivered without even the use of instruments.

*The Treatment of Fibroid Tumors.*—As a great change for the better has taken place in the results of operative treatment, a few words on the subject may be of interest. Twenty-five years ago the mortality in the hands of even the best operators was nearly seventy-five per cent., and fifteen years ago it was something like twenty-five per cent. No wonder, then, that at that time Apostoli's discovery was so heartily welcomed that nearly all of these patients couldbe cured of their symptoms by means of electricity and without any death rate at all. While the abdominal surgeons, rather than face such a risk, wisely advised their patients to do nothing, or only to take medicine as long as the tumor was not threatening their life, and even when it was threatening the woman's life by hemorrhage or pressure symptoms, the physician had no other resource to offer than the always doubtful one of ergot. The almost certain chance of being cured by electricity was a great boon, and I lost no time in going to Paris and learning Apostoli's method and in being the first to introduce it into Canada. Although I succeeded in curing of all their symptoms sixty-three women out of ninety-seven who were sent to me during thirteen years, I would have been glad during all that time to have completely removed the tumor by operation just as soon as the death rate could be reduced to its present low rate. During all those years, therefore, I urged electricity first, and, when it failed, I had recourse to Trenholme's operation of removing the tubes and ovaries, which, while it did not remove the tumor invariably in my hands, at least, sooner or later, cured the symptoms and caused the tumor to be considerably reduced in size. I say sooner or later, for in some few cases I had to wait a year, and in one case nearly two years before the hemorrhages entirely ceased. Another objection was that, while this operation did not remove the tumor any more than electricity did, it had a death rate of 7 or 8 per cent., which electricity did not have. When Lawson Tait, Kœbreli and Joseph Price

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perfected the method of removing fibroids with the *serre noeud* and transfixion pins so that the death rate gradually came down to ten per cent., I began to adopt this operation in all cases in which electricity failed, or in which the patients could not spare the time required for electrical treatment. A few years later Baer and Kelly so improved the technique of abdominal hysterectomy that the mortality fell gradually to five per cent., and even in Kelly's hands to two per cent., he having recently completed one hundred consecutive cases with only two deaths. I am now employing this method in every case that will consent to an operation, and I have now done *ten consecutive cases without a death*, the tumors ranging from one to five pounds in weight, so that my attitude has completely changed, and I now deem it my duty to urge every woman with a fibroid tumor to have it removed immediately. The gynecological journals, during the last few months, record many instances in which fibroid tumors have sloughed, suppurated, become twisted and become malignant, so they are no longer considered the benign tumors they once were. Malignant degeneration has occurred three times in my experience (among those I was treating with electricity). And last, but by no means least, the earlier the tumor is removed the safer it will be to remove it, because there will be no adhesion to bowels, no enormous sinuses to bleed and smaller arteries to tie, and the woman's general health will be better able to bear the operation, while the operation itself will be ever so much easier to bear.

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# Selected Articles.

## HEADACHES AND THEIR TREATMENT.

T. LAUDER BRUNTON, M. D.,
St. Bartholomew's Hospital.

Before commencing the discussion of the treatment of headaches it will be advisable to come to an understanding regarding the meaning which we attach to the word "headache." Although it is by the brain that we perceive pain, yet the brain itself, when subjected to direct irritation, give

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rise to no feeling of pain. It is only when it is excited through the medium of peripheral nerves that the sensation of pain is felt. This is the case with pain in the head as well as pain in other parts of the body, and to the pains which are confined to the head the name of headache is often given, but not always. We find that if pain is localized in a particular organ in the head we do not, as a rule, apply the term "headache" to it. We speak of toothache, of earache, and perhaps of eyeache, but not of headache unless the pain is of a more diffuse character. When it is localized in a part of the head other than the eye or ear, but is of a shooting character and is limited to one particular spot, we often apply the term neuralgia to it. By headache we generally mean, then, a more or less diffused pain in some part of the head. There are two kinds of pain, however. There may be a sharp shooting pain in one particular part of the head or in one particular organ, and associated with this there may be a diffused pain, so that we may have at the same time a toothache and a headache. Not infrequently the headache depends upon irritation in the teeth, in the eye or in the ear, but often the cause of the headache is irritation of the nerve fibers either in fibrous structures in vessels.

The pain which is associated with tumor in the brain is probably due to pressure of the tumor upon some of the fibrous structures within the cranium; but the headache which is associated with various nerve conditions and is known as migraine is probab'y due almost entirely to the stretching of the nerve fibers withing the blood vessels. Various opinions have been advanced with regard to its pathology. Some say it is due to cramp of the vessels and that the vessels during the paroxysm are firmly contracted. Others say that during the paroxysm the vessels are widely dilated. In my own case I have found that both statements are true and both are untrue, both being imperfect. The fact is that I get in migraine a dilatation of the proximal parts of the carotid artery with a contraction of the peripheral part, and that if I take off the strain from the vessels by pressing the carotid the pain is at once relieved.

Now, in regard to the pathology of headache, we have to consider two things, namely, (1) a general condition and (2) a local condition. The general condition renders the patient liable to pain, the local condition determines that the pain should affect his head rather than his intestines or his big toe or some other part of his body. The general conditions which lead to headache are those either of (a) imperfect nutrition or of (b) disordered nutrition. We find headache very commonly in imperfect nutrition, such as anæmia, and

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perhaps still more commonly in disordered nutrition, such as occurs in rheumatism, in gout, and, above all, in albuminuria. In all those cases the tendency to headache is more or less constant, because the disorder of nutrition is more or less permanent. But in apparently perfectly healthy people we find that headaches come on now and again, and they are apt to come on with more or less regularity. Thus it would appear that in many such people there is a tendency to disordered nutrition occurring with more or less regularity, and such patients are accustomed to recognize this in themselves, and to say that they are apt to become bilious. We find this regularity occurring most markedly in women, because, just before, during or after the monthly period, women are very liable to suffer from headache. But in men, where there is no monthly period, we find also a tendency to regular recurring headache, and probably in them also there is a regular alteration in nutrition.

Now, the nature of this alteration is rather hard to determine, because our knowledge of nutrition generally is insufficient. Yet, a common observation may allow us to associate this altered nutrition, more especially with one organ, namely, the liver, because men and women are accustomed to say that they are liable to bilious headaches which recur every now and again. In order to understand this recurrence it is necessary to consider the functions of the liver.

The liver is a porter which stands at the gate of the organism and prevents all the deleterious substances which pass into the intestinal vessels from the intestine from reaching the general circulation. These substancess are caught by the liver; they are either destroyed or transformed by the liver, or excreted by it unchanged into the intestine. From the intestine they may partially pass away with fecal matters, but many of them may be reabsorbed, and so they go on in a continual round from the intestine to the liver, from the liver to the intestine and back again to the liver until at last the amount of these substances becomes so great that the liver is no longer able to deal with it, and they pass through the liver and get on into the general circulation. Now it would appear as if there was a certain period required for this accumulation. The period will vary in different individuals, but it will also vary in the same individual under different circumstances, and more especially we know that it will occur in the same person in a less time when he is on a more highly nitrogenous diet. You know that it has been shown that during the decomposition of albuminous materials in the intestine various poisons are formed, and these poisons

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probably accumulate in the liver until they get through it into the general circulation. By putting a man, then, upon a non-nitrogenous diet you lessen the proportion of these substances, and so you may increase the intervals between the headache more and more, until you may make the interval indefinite and prevent the headaches from recurring at all. Absorption from the liver is greatly altered by emotions. So much is this the fact that sometimes after emotions a person may become completely jaundiced, absorption having taken place so quickly from the liver that the bile actually colors the conjunctiva and the face. Therefore we should expect that anything which was circulating with the bile in the liver would be rapidly absorbed in consequence of emotion. We find that anxiety, grief, sorrow, especially any depressing emotion, is apt to bring on headache. We have, therefore, very good reasons for attributing many headaches to the presence of abnormal constituents circulating in the blood. If this idea be true, we ought to be able to relieve headaches by clearing out many of the morbid products from the liver. Experience has shown this to be the case, because one of the best methods of relieving a headache or preventing it is to give some mercurial cholagogue, following it up by some saline aperient. A blue pill over night and a black draught next morning will very often prevent the headache from occurring at the time when the person was perfectly sure it would otherwise come on.

So far, then, for the general condition of poisoning by toxins; but there are other injurious substances even less known. Many of them are classed, I believe, under the head of uric acid, and certain substances connected with gout and rheumatism are very apt to produce headache. The most powerful cholagogue that is known is salicylic acid or salicylate of soda, and one of the most powerful remedies in preventing and relieving headache is the latter. We may conclude, then, that a good deal of the misery caused by headaches is due to the absorption of toxic products, and that we may prevent headaches from coming on by the use of cholagogues and aperients.

But why do toxins fasten upon the head and cause headache instead of causing man to suffer from pain in his intestines or in his big toe? The reason is that in most cases we have some local lesion which determines the pain to the head, and the most common lesions are either decayed teeth or something wrong with the eyes. The abnormality in the eyes varies a good deal. In some people it is simply a little inequality in the visual length of the two eyes; in others it is astigmatism, in

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others it is want of accommodation. In others it may be presbyopia, or it may be hypermetropia. In all cases of headache the first thing to do is to examine the teeth and see if any are decayed; next the eyes, and see if there be any abnormality in them. The most common cause of headache is certainly some abnomality in the eyes, but you will find that a great many patients show nothing wrong with the teeth, nothing wrong with the eyes, and then you must look for some other cause. You examine the ears, and see that there is no tenderness in them; you look at the back of the throat and see that there is no thickening of the mucous membrane of the posterior nares, tending to block the Eustachian tubes, and thus indirectly affecting the ears.

A still more frequent cause of headache, however, probably is irritation in the nose or in the cavities connected with it. A very common cause of headache in winter is irritation in the nasal mucous membrane spreading upwards into the frontal sinuses and giving rise to frontal headache. In some other cases, again, you will find that it spreads towards the antrum of Highmore in the malar bone, and you then get a one-sided headache. There is nothing to prevent the irritation from spreading to the ethmoidal and sphenoidal sinuses, and probably it does so spread, and in many cases headache, especially when felt right in the middle of the head, depends upon something wrong in the sphenoid or ethmoid, but we know less about this, and we cannot deal with them so easily. Yet it is necessary always to bear in mind the possibility of these cavities giving rise to headache in cases where you cannot find any other cause for it.

Headaches, and especially the headaches known as migraine, may be accompanied by various other symptoms. In ordinary cases migraine depends upon some spasm of the vessels outside the head, but not infrequently there may be spasm of the vessels inside the head, and then the functions of the brain may be effected. The function of the cerebrum are, as you know, vision, sensation, hearing and motor-power, to say nothing of general sensation. If spasm of this vessel should so occur as to interfere with the free circulation of blood through the cerebrum, symptoms will ensue whose nature will depend upon the position of the spasm. Supposing that spasm occurs at such a point that the occipital lobe will be deprived of a good deal of its blood, visual hallucinations will probably ensue, and these are amongst the most common concomitants of sick headache. People suffering from sick headache are very apt to get a zigzag appearance in front of their eyes. They at the same time frequently experience a difficulty of seeing. They look

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at a book, but they cannot read ; the lines waver like the air over a field on a hot summer's day. These zigzags are generally colored, and very often amongst other colors there is a green color.

We do not often hear of any hallucinations of smell or taste accompanying migraine, so that probably the contraction of the vessel stops nearly opposite to the ascending parietal branch. But sometimes patients may complain very distinctly of motor symptoms, and one of the most marked is aphasia, and in some cases of sick headache you will find your patient may become completely aphasic. How far this is due to the occurrence of atheroma within the arteries I do not know, but in one patient in whom the aphasia was well marked during an attack of sick headache I found after death, which resulted some years subsequently from hemorrhage into the pons, that the cerebral arteries were studded with atheromatous patches.

In tumor of the brain the headache is intensely severe, but it is almost always accompanied by severe vomiting, which is of a peculiar character, unassociated with nausea. It is sudden and violent, and immediately after the vomiting is over the patient feels well again and is able to eat. Associated with those two cardinal symptoms we find optic neuritis, and, when we find a headache without the other two symptoms, the probability is that it is functional and not due to any tumor whatever in the brain. Another cause of headache seems to be associated more with some of the fibrous tissues. There may be inflammation of the periosteum of the head, just as there may be inflamation of the periosteum of any other bone, and this inflammation may affect the periosteum either from gouty, rheumatic or syphilitic irritation.

Treatment.—The first method of treatment in headaches is of course to try to supply the brain with healthy blood ; to clear away any toxins that may be present in it; and one method of doing this I have just mentioned—namely, the administration of a blue pill and a black draught. But more than this, we may try to give something which may have the power of counteracting these toxins or of producing elimination from the liver, and I have found by personal experience the easiest way of getting rid of the toxins or of counteracting their effect, I do not know which, is to keep up the action of salicylic acid or salicylate of soda. So that in persons who are liable to headache I generally prescribe salicylate of soda, 15, 20, or 30 grains at night, with 10, 20, or 30 grains of bromide of potassium. This mixture acts better than either salicylate of soda or bromide of potassium alone, and it will

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usually prevent the occurrence of a headache in the morning.

If, however, the headache should still come on, I recommend that the dose should be repeated, and in the case of people who suffer from very violent and often recurring headaches I give them the salicylate soda not merely morning and night, but three times a day, in small doses, either immediately before or after meals. The salicylate of soda is apt to produce a certain feeling of depression and weakness, and in order to counteract these I generally give it along with half a dram of aromatic spirit of ammonia. Some of my patients have taken salicylate of soda for several years without any apparent harm, but we know theoretically that all these drugs allied to salicylate of soda have a tendency to produce anæmia; and it may be advisable in some patients if you are giving the salicylate of soda regularly to give also a little iron to counteract the effect of the salicylate in producing anæmia.

There is another large class of drugs that are used for relieving headache. These, I should mention, ought always to be given before the headache becomes too severe, because when it is severe absorption from the stomach appears to be arrested, and many patients will tell you that the first dose they had of antipyrin acted like magic, but the next time they took it it had no effect whatever, and you can tell them the reason why. The first time they took it was before the headache had got very bad. It was, therefore, absorbed from the stomach and acted upon their nerve centers. The second time they waited too long, until the headache had got so bad that absorption ceased, and so the antipyrin was no more use to them in their stomach than in a bottle outside. Where you have to deal with headache it is always advisable to give your drug before the headache gets too bad. All these belong to the class of drugs which act upon the conducting fibers or cells in the cord and tend to disperse pain. I dare say you know the old story of the dirty Scotch woman. A lady came in to see her one day and found the children walking and grubbing about, and she said to her: "Do you not often wash your house?" "No," said the woman. "But when the children come in with a lot of mud on their boots and they tramp all over the floor, what do you do?" "Oh, I make them knock it about until there is none." She distributed the mud equally all over the floor and then she thought it was all right. Now that is what these drugs do to the pain.

Painful impressions do not pass to the cerebrum straight up as a rule, because, as you know, pain is largely conducted

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up the central column of the cord, and not up through the straight fibers which conduct tactile sensation. If you can distribute your sensation so much that it will get broken up in the cord and will not reach the center for pain in the brain, of course the patient will not feel pain, and so antipyrin, nux vomica, strychnine, phenacetin, antifebrin, and all that class of drugs relieve pain with one exception—namely, if the pain be not too severe. If the irrtation of the sensory nerve is so great that it will fill up all the channels for pain, then phenacetin or antipyrin may sometimes make the pain worse than before. I did not believe this; I thought it was quite contrary to anything that could possibly be, but a patient of mine told me that the antipyrin which I had prescribed to relieve headache made him very much worse. I thought he was mistaken, but I have no doubt he was quite right, and that the reason was that the irritation was so intense, for it seemed to him that the pain had been increased tenfold by this drug.

But there is another drug that is very much used, and which has a somewhat similar action, but it acts apparently more upon the posterior columns than upon the central columns—at least so far as experiment goes—and that is caffeine. In cases where the pain is so intense that these substances, instead of relieving it seem to make it worse, there is perhaps no drug to which you can have recourse except the subcutaneous injection of morphine, and that relieves the pain and gives the patient quiet for the time being. But of course there is always the difficulty of the morphine habit arising, and so you put off the use of this drug as long as you possibly can. In some cases where there is continued pain in the head lasting for a length of time cannabis indica seems to help, and this may be given either in the form of the extract or tincture. It is easier to regulate the dose of the tincture, and you may begin with 10 minims three times a day, gradually increasing the dose. You must be careful about cannabis indica. There is no danger in it, I think, but you may greatly alarm the patient's friends if you run beyond 15 or 20 minims until the patient is accustomed to it. You may bring on a state of maniacal excitement which will greatly alarm the patient himself and everybody around him, but the long-continued use of this drug will sometimes relieve these headaches when other things seem to fail.

For the relief of headache occurring through inflammation of the periosteum from gouty rheumatic irritation, it is fortunate that one remedy is very useful—namely, iodide of potassium, which should be begun in small doses, and

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gradually increased up to 10, 20, or 30 grains, three times a day. Where you think that the pain is not of a pure nature, not due simply to dilatation of the nerve fibriles in the fibrous tissue of the periosteum, but is associated also with some change in the vessels of a nature allied to them, which we find in sick headache, the iodide may be combined with bromide and salicylate, and in all those cases it is advisable to give some aromatic spirit of ammonia along with it in order to prevent any depressing effect of the drugs.

There is one thing more. Whenever you get a case of intense headache which your drugs fail to relieve, always look out for glaucoma. Even in ordinary headache you will be very apt to find the affected eye is rather tight, that the intra-ocular tension is higher than usual, but in glaucoma it is very much increased, and this will be permanent, and not temporary as in ordinary sick headache. In cases where this increased tension exists you must either treat the glaucoma yourself, or have the patient operated upon by some specialist so as to prevent the loss of an eye as well as to relieve the headache which is so intense, and which comes along with the disease.

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## MEGRIM.

By A. LOCKHART GILLESPIE, M.D., F.R.C.P. ED., F.R.S. ED.
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Among the various forms of disease to which our bodies are subject, a certain number there are which seem to be regarded by the victims in the light of ordinary everyday occurrences, annoying and disagreeable no doubt, but only what is to be expected by the majority of suffering mankind, and not of sufficient importance to call for treatment. Megrim may be classed among them. How often do we not hear it stated, "Oh, So and So could not come, she has one of her sick headaches;" or to our question as to the health of a friend get the reply: "I am quite well, only have had a sick headache." Possibly the term is often employed to cover many other conditions, notably by women; but the frequency of the excuse and the slight importance paid to the announcement of the cause, serve to illustrate popular conceptions as to the slight significance attaching to megrim attacks.

It is an interesting fact that in Edinburgh, at least, very few patients apply for hospital in-or-out treatment for migraine alone. Out of thirty-five thousand three hundred and forty-six patients treated in the medical wards of the

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Edinburgh Royal Infirmary from October, 1891, to October, 1898, only nine are recorded as having suffered from this disease alone; that is, only one in three thousand eight hundred and seventeen sought or was given treatment, or 0.025 per cent. Among the medical out patients, averaging at least nine thousand, five hundred a year, or about sixty-six thousand, I can find very few diagnoses entered of megrim. There can be no doubt that many of those applying for treatment or advice for other troubles, also suffered from sick headaches, but attached little importance to them, imagining them to be migraine. Hemicrania, sick headache, vertigo, megrim, are synonymous terms applied to a train of symptoms as common as they are peculiar, as distressing as they are common. Obviously of nervous causation, often independent of digestive disturbances, the symptoms are so intimately connected with those procedures common to gastric and hepatic upheavals, that they have come to be associated with these organs. But the sufferer from the severest forms of gastric dyspepsia, the yellowest victim of catarrhal jaundice, the subject of hepatic congestion or of duodenal antiperistalsis, who vomits bilious matters, or the obstinately constipated, do not nessarily undergo the torments of a megrim. *Per contra*, the individual who experiences migranous attacks may have no dyspepsia, no liver fault, no excessive obstipation. The first class suffer from the effects of local digestive disorders; the second from a more or less general affection of their nervous mechanism.

All that is necessary to assume is that some conditions of the circulating fluids of the individual organs, or of the nervous system as a whole, able to produce the special state of irritability and local paranoia of the nervous tissues concerned in migranous attacks, must be present. Attacks of migraine can be separated into one or more classes:

1. The accidental paroxysm occurring at rare intervals, irregularly, perhaps only once in a lifetime; an accompaniment of some acute dyspeptic or hepatic condition. This is truly a digestive sick headache.

2. The similar variety occasionally met with after severe exertion, especially on insufficient food and in the untrained. The acute form of metabolic migraine.

3. The common, one might almost say the family variety of migraine, due to chronic auto-intoxication and deficient exercise. The chronic form of metabolic migraine.

4. The functional or neurotic form, akin to epilepsy rather than to hysteria, possibly in part and to a lesser degree due to conditions similar to those in number three, and aroused by slighter stimuli.

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In men, I believe, attacks of hemicrania almost always indicate inefficient metabolic processes, primarily in excretion, secondarily in anabolic and assimilative actions and often appear when their manner of life alters ; for instance, when they pass from school to office stool, or from playground to student's class-room bench and midnight oil. I am, perhaps, inclined to attribute greater significance to the results of indoor employment as the casual agent in many cases of megrim, because my own attacks arose from this, and because I have seen complete recovery take place, after prolonged treatment by other methods had failed, when energetic non-medicinal measure were adopted *con amore*.

Latham, in his classical work upon megrim, christened a paroxysm a " nerve storm," a complete definition and a comprehensive description in itself.

Before the storm a calm, befor the megrim attack comes a period of especially bright mental weather. As the mercury begins to dip, cirrus clouds, followed shortly by stratus, partially veils the sky in the eye of the rising wind, hinting at the coming stress ; so a cloud advances over a portion of the visual field, frequently obscuring in time a full half of it, foretelling, in more abrupt fashion than the meteorological omens can, the onset of a " nerve storm." Still later the phenomena, atmospheric and ocular, may further coincide ; the lightning of the thunder cloud, a prototype of the zig-zag bright lines and flashes of light, albeit that these are more akin in color scheme to the rainbow than the electric spark, often disposed after the manner of the outlines of one of Vanban's medieval fortification plans. The nervous and atmospheric pressure still falls, the air feels oppressive, and so the brain, until the crisis approaches, the glass stops falling, begins to rise ; the atmosphere is freshened by discharge of rain, the nervous system by some critical evacuation or excretion, by vomiting, free perspiration, evacuation of the bowels, or copious discharge of urine.

The recovery of normal pressure is usually more rapid in nature than in the body, but profound sleep, as a rule, supervenes, and after a shorter or longer period the nervous isobars resume an anticyclonic type, and the condition is once more " set fair."

In those cases belonging to the first two classes the digestive sick headache and the acute metabolic megrim, the cyclonic disturbance in the nervous atmosphere is like unto the sudden cyclones of America, and tropical regions—short, sharp, occasional. Those belonging to the other two classes correspond more to the regular barometric depressions which are necessarily born over the oceans, owing to the variations

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in temperature of the ocean currents, the air above them, and the earth's revolutions.

That the involvement of the nervous system is by no means a mere reflex result of local irritation of the nerve endings in the mucous membrane of the stomach or small bowel, is shown by the frequent absence of any sign or symptom other than the megrim itself pointing to digestive disturbance in these organs, and by the not uncommon occurrences of symptoms of profounder nervous affections, either during the latter stages of a paroxysm, or, and this more often, post-paroxysmal, such symptoms as aphasia, slight mental confusion, temporary anesthesia over various areas of the body surface, even paresis and slight ataxia.

In dogmatizing as to the etiology of affections such as migraine, one must needs beware of narrowness of view. The nearest approach to truth in controversial subjects is best made by taking a middle course, nor is it well to assume that any one disease is always the result of one invariable cause. Migraine is a case in point. The combinations of symptoms undoubtedly vary, often widely, but the symptoms themselves denote nervous disturbances of a special type, affecting a larger or smaller region in a greater or lesser degree. The primary source of this disturbance in portions of the nervous system cannot, however, be particularly assigned to only one cause, or even to one class of lesions.

Now as to my personal experiences. I was first attacked with megrim after leaving school and beginning university work. Every three weeks or so one would occur, except when I was on holiday and led an open-air life. Was treated in the ordinarily approved style with cholagogues and cathartics, but though lighter in weight still suffered. But, having read Latham's treatise, I foreswore medicines, and began climbing a hill of eight hundred feet in the outskirts of Edinburgh and in a hurry, four or five times a week throughout each session, during an off hour between classes. No megrim has ever troubled me since then, save once when, after a fifteen miles' walk in the Highlands, the place at which I had expected to be able to get some food I found closed, and the second fifteen miles on a tightened belt proved sufficient to bring on what was but a slight attack. In this last case the true cause, very probably, is to be found in an excess of the products of muscular waste, in a somewhat starved blood stream. The physical exercise of surmounting the hill referred to, more than a mile and a quarter from the university, with an ascent of nearly six hundred feet from the lowest point touched, and in returning in forty-five minutes or under, was considerable.

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Some time back I had occasion to treat a schoolmaster, newly come from another institution, who for two or three years had been a victim of hemicranial attacks about every fortnight, their first appearance coinciding with his introduction to the duties of his office. He was of billious temperament, whatever that may imply, in so far that his skin was sallow, and that he had had several mild attacks of catarrhal jaundice; since then he has suffered from several of the same, but the catarrhal affections of his liver did not appear to have any relationship whatsoever with his migrainous bouts. He had previously endured much physicking and stimulation of his liver, with no good result on his sick headaches.

As instructed, he desisted from all drug-taking; put on as many layers of flannels, sweaters, old clothes, as he could place atop one another, an overcoat above these, and every afternoon during an hour's respite from duty, proceeded to cover two or three miles at a smart running pace, which, while well within his powers of endurance as to both distance and rate, produced in him a distinct feeling of having done some hard work, and of having caused a free secretion of sweat.

On return he disrobed, took a cold plunge, a rub-down with a rough towel, dressed and rested on a couch until his time for duty arrived. This patient only experienced one attack after commencing his daily run, and that occurred during the first fortnight and was very slight. He has had no further recurrence, although for a year past no special form of exercise has been taken. Nevertheless he has, since the megrim ceased, shown symptoms of liver disturbance, has been bilious, jaundiced, and cholemic, without any trace of a nerve storm initiated or brought to a point by it.

In him a sharp daily burst of active exercise, sufficient to cause fatigue, but not enough to over-tire him, stopped his attacks. Nor did they recur afterwards.

If this patient had been recommended to take daily constitutionals at his own pace, in the open air, it is almost certain that he still would be subject to megrim. Constitutionals, as a rule, are fraudulent proceedings. They savor so much of "needs must;" they tend to remind the actor that he is unhealthy, and during their monotonous performances great opportunities are offered for introspective brooding, and they seldom are productive of any marked muscular exertion, for walking at the ordinary "constitutional-by-order" pace requires little expenditure of energy. Energetic exertion, short and sharp, is productive of greater benefit to migrainous patients, and also to dyspeptics, if carried out in

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a natural manner in the open air, than any sedate constitutional or indoor employment of dumbbells, Indian clubs, and their allies.

The facts in the case illustrate very plainly some of the points I wish to refer to, and closely reproduce the salient features of various other cases which have come under my observation. No clear relationship between the occurrence of the attacks and any definite exciting factor could be traced; but every fortnight or thereabout, his indoor life and the mental strain imposed on him in the teaching of children, lend to accumulation of effete metabolic products in his blood and tissues, probably also to increased irritability of his cerebral centers, until what time the nervous mechanism, stimulated no doubt at first, and so causing the precedent feeling of well-being and vigor, became over-stimulated and was forced to find a vent for its unhealthy generated surplus energy along the lines of least resistance.

The following case belongs to another category. The history, briefly put, runs thus: A lady, twenty-five years of age, unmarried, well dowered with means and living an idle, empty life, had, since the establishment of her menstrual functions, suffered from severe sick headache every month in connection with her periods. Between times her health was as good as too little to do, sluggish bowels, and too rich foods, would permit. Of a neurotic stock, the continued appearances of these attacks from the two causes, inefficient use of over-rich foods and of the products of wear and tear of her tissues, along with monthly recurrence of a sufficiently disturbing factor to reflexly initiate an overflow of misdirected nerve energy, her case was more serious. But here again, sharp muscular exercise out-of-doors up to but not beyond the limit of honest fatigue served to raise the tone of her nervous system above the level, at which they responded too energetically to the monthly stimuli, while they also lacked an over-store of abnormal potential energy.

*Treatment.*—No active measures designed to relieve the actual paroxysms are of any avail in warding off future attacks. But given a paroxysm to treat, how best can this be done? By absolute rest and quiet, by allowing no food (if food be desired, as is seldom the case) but a little milk, or tea and toast; by giving a dose of caffeine (the citrate is not so good), dissolved in strong black coffee, and ordering a purgative enema. In the early stages aperients by the mouth are seldom indicated, for when taken they rarely pass through the stomach, more often returning by the way they are introduced. The peristalsis of the stomach is in abeyance unless it be to excess in the wrong direction. Various drugs

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have been from time to time vaunted as specifics, antipyrin, antipyrin with caffeine, phenacetin, cannabis indica, etc., among them, and frequently do good at first, generally to lose their influence over later attacks. Where arterial spasm is present the various nitrite compounds may give relief.

It is during the intervals that real benefit must be sought for, and here the main factor to be considered is the nature of the exciting cause, if it be local and general, or general alone. Treatment must proceed along rational lines for removal of any irritating lesion as well as towards improvement of the metabolic processes of the organism. Benefit to one of these conditions may suffice to render the effect of the other insufficiently marked to cause attacks.

Each case has to be considered on its own merits. The physician must endeavor to arrest the manufacture of surplus nerve force, generated by constant, even if slight, irritation, or conversely to get rid of the surplus by some means or other, thus preventing its accumulation and consequent eruption, by measures which appear best adapted for the case. Local and remote affections must be sought for, and when detected relieved. To advocate any one strict and invariable mode of treatment for any simple disease on every occasion is the essence of folly. The same effect may be gained by different methods ; the same symptoms proceed from dissimilar combinations of causes, and amenable, therefore, to different lines of treatment.

As in epileptics who are generally benefited by hard manual and physical labor, so those victims of migraine who exhibit post-hemicranial mental symptoms of increasing severity as time progresses, are usually much improved by hard out-of-door work. Often one will be told by a patient who has been advised to exert his muscles more, that he is never off his feet, and gets more exercise than he likes. The truth being that exercise of this character, indoor chiefly, or in towns in the course of non-manual business, does little good, and often harm. It fatigues, rather than healthily tires.

Many sufferers from migraine will be found to avoid butter and fats, or to partake of them sparingly, either from personal dislike or because they disagree ; or, again, if fond of fatty foods, they may not be able to make use of them.

Constitutional conditions may require attention ; the gouty, syphilitic, rheumatic, and the malarial, often benefit greatly from corresponding specific remedies, alone or along with drugs specially indicated for the disease itself.—*Med. Brief.*

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# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

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### ABNORMAL SELF-CONSCIOUSNESS IN CHILDREN.

When the child's appetite is good and his temperature normal, most physicians are apt to think him safe in his mother's care and no longer dependent upon medical advice. Yet, if we counsel correct habits of diet, exercise and sleep, we ought not to be considered as transgressing very far the legitimate bounds of medical practice if we essay occasionally a warning word about so bad a mental habit as self-consciousness. Such advice when given to a reasonable mother, may be in the best sense prophylactic. Few parents can be gotten to believe, for example, that "forwardness," disobedience and rude conduct in a young child are sometimes a grave sign of mental deficiency. Gowers has noted them as one of the earliest indications of abnormal cerebral function. Instead of the youngsters being prompted to rudeness and impertinence, and laughed at for his supposed precocity, such performances should be viewed with anxiety, and should be gently but promptly suppressed. That small children should be "seen and not heard" is a maxim based on an enlightened psychology. The abnormal self-consciousness that prompts such outbreaks can easily develop into an incurable egomania; the growing brain tissue is, as Horace so well said long ago, *cereus in vitium flecti*. Even where it is not congenital, a morbid feeling of self can be awakened and nourished with alarming ease and speed. No child should be encouraged to repeat poetry before his mother's guests, or praised for his "pretty curls," or even have his first trousers made too much of. The less he thinks of himself the better. He may be judiciously commended for good conduct or for diligence in study, but never flattered for his cleverness and good looks, or anything which he has not come by through self-forgetting endeavor. Both boys and girls should be taught to *endure;* to neglect trifling aches and pain, and seek for a remedy rather than cry over the trouble. Self-command and self-control are the noblest things a man can strive for,

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and he will never gain them unless he began learning in infancy to fix his thought and will upon objects outside himself. If such principles of education were more closely followed, hysteria and the "artistic temperament" might gradually disappear, and the hosts of insane people now walking at large, because their disorders of consciousness are not directly menacing to society, might be much diminished. Improper marriages are, of course, at the root of the evil. Bad training is, however, almost as frequent a cause, and is one which in the present state of society is much more readily remediable. To MacBeth's famous question, "Canst thou not minister to a mind diseased?" the modern physician should find a better and braver answer than that of the doctor in the play, "Therein the patient must minister unto himself."—*Pediatrics.*

## ANTIDOTE FOR CARBOLIC ACID.

Dr. Seneca D. Powell, of New York, has for a long time used in his clinics at the Post-Graduate Hospital an antidote, alcohol, that we have all come to recognize as a specific. It is not an unusual occurrence to see Dr. Powell catch in his open hands a quantity of pure carbolic acid, poured into them by a nurse from a bottle. In a few moments the doctor puts his hands into a basin of pure alcohol, and no escharotic effect is observed whatever from the action of the carbolic acid upon the skin. At present time we are flushing out abscess cavities with pure carbolic acid and washing them out a few moments later with pure alcohol. In empyema Dr. Powell, after making a large opening in the chest wall, washes out the cavity with a ten per cent. solution of carbolic acid, after which pure alcohol is used, and no bad effect has thus far been observed from this treatment. The cavity of the pleura is rendered aseptic. From personal observations and demonstrations in the use of pure carbolic acid, followed by the use of alcohol, Dr. Phelps states positively that we have in alcohol an absolutely safe and sure specific against the escharotic action of pure carbolic acid. This fact should be given wide publication, becauses in cases of carbolic acid poisoning with homicidal intent, if, immediately after the administration of the poison, alcohol was thrown into the stomach of the individual, the poisonous effect of carbolic acid would be at once neutralized. However, as to the subsequent constitutional effect from the absorption of the new compound formed Dr. Phelps cannot speak, but certainly in all cases of local carbolic acid poison-

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ing, particularly in such a case as that mentioned by Dr. Weiss, alcohol is an absolute, powerful and immediate specific. —*Va. Med. Semi-Monthly.*

## EFFECTIVENESS OF ANTI-TOXIN IN THE TREATMENT OF DIPHTHERIA.

Dr. J. J. Kinyoun, United States Marine Hospital Service, in charge of the Bacteriological Laboratory at Washington, in an article published in the *Forum* for August, gives a lucid historical sketch of the progress and efficacy of the anti-toxin treatment of diphtheria. The treatment began to be used in the Berlin hospitals in 1894, and the first full year of the anti-toxin period was 1895. The following is the hospital record at Berlin for the years specified in cases of diphtheria and membraneous croup, which latter disease has been found to be generally due to the diphtheria bacillus, and which consequently yields as readily to the anti-toxic treatment as diphtheria: 1892, 3,683 cases with 1,342 deaths; 1893, 4,315 cases with 1,637 deaths; 1894, 5,220 cases with 1,416 deaths; 1895, 6,106 cases with 987 deaths; 1896, 4,345 cases with 559 deaths; 1897, 3,723 cases with 546 deaths. The anti-toxin was used for three months only in two of the hospitals in 1894, and the death rate fell from 37.7 per cent. in 1893 to 27.1 per cent. In 1897 the death rate had fallen to 14.6 per cent.

In the Kaiserin Friedrich hospital, in 1894, the new treatment was used from March to September, and the mortality in all cases of diphtheria and croup was 15.6 per cent. From September to November no further supply of the serum could be obtained, and in that period the mortality rose to 48.8 per cent. Then a supply of serum came to hand, and on a resumption of the new treatment the mortality rate at once fell to the former percentage. This was a demonstration of its effectiveness which could not be explained away.

The Paris statistics do not give the whole number of cases treated, and we must judge from the number of reported deaths from the two diseases in question. From 1886 to 1893 the number of deaths averaged about 1,500 a year. In 1895, the first year in which anti-toxin was generally used, the number fell to 993; in the next year to 411; in 1897 to 444, and in 1898 to 274. The record of the London hospitals is not equal to that of Berlin and Paris, but there, too, the death rate has been greatly reduced. In New York during 1894 some 2,900 deaths from the two dis-

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eases were reported; in 1898, under the new treatment, the number was only 900. In Boston the death rate from these causes averaged nearly 31 per cent. from 1880 to 1894; from 1894 to 1897 it was only 12.6 per cent. In Chicago the rate prior to 1895 had been over 30 per cent.; since then it has fallen below 10 per cent.

Prior to the introduction of the anti-toxin treatment recovery from croup was rare, unless effected by tracheotomy or intubation. Reports upon 5,546 cases before 1892 showed a death rate of nearly 70 per cent. Another investigator collected reports of 12,736 cases occurring prior to 1887, where the death rate was 73. Now all this is changed, and out of 1,074 cases reported to the American Society of Pediatrics only 668 required surgical treatment, and the percentage of recovery for all was nearly 79 per cent., as contrasted with a former death rate of 70 per cent. Tracheotomy is now giving way to the milder operation of intubation, and even this is becoming less and less necessary, owing to the prompt application of the new remedy. It has been stated by Dr. Behring that if this remedy could be applied on the first day of the disease there would be practically no mortality from diphtheria, and Dr. Kinyoun fully concurs in this.

The question at once arises here why anti-toxin may not be administered to persons exposed to a diphtheria or croup epidemic as an immunizing agent, as vaccine virus is used against possible exposure to smallpox. While the two diseases differ materially in the nature of their origin, there is good reason for believing that preventive treatment may be as successfully pursued in the one case as the other. So far as tried, it has met the most sanguine expectations. It is mentioned in the *Forum* article that a Dr. Briggs has collected reports of 20 000 cases of exposure to diphtheria which have been treated with immunizing doses of anti-toxin, and only one fatal case was known to occur, while only 109 cases of the disease in a very mild form developed. It may soon be that "anti-toxication" will be made as prevalent among children and others as vaccination.—*The Sanitarian.*

## COLD WATER vs. MEDICINAL TONICS.

The numerous medicinal tonics, so called, are universally toxic in character. Whatever tonic effects they may seem to produce are due to the fact that the system is aroused to resist their influence and to expel them from the body; and

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while a certain amount of benefit is perhaps derived from the use of such agents, there is always a possibility of serious damage; and doubtless in all cases a considerable amount of harm is done through the toxic influence of the drug, which falls with especial weight upon those organs which are most concerned in its elimination—the liver and the kidneys.

A medicinal stimulant is a mortgage placed upon the vital capital of the body, which must be paid sooner or later. It is a draft upon the constitution. A stimulant is simply a means by which the nerve centers are made to give up a little more of the energy which they have stored up, and unless the stimulus is of such a character that the storing power as well as the expending power of the nerve centers is increased, there must be a loss from its employment.

A toxic agent, like strychnia, may provoke the expenditure of nervous energy, but it does not replenish energy; while it does lessen the activity of the kidneys in eliminating tissue poisons, and the efficiency of the liver in the destruction of toxins and leucomains, thus encouraging the development and maintenance of a condition which is, in itself, an indication for the necessity of employing tonic measures; in other words a medicinal tonic or stimulant aggravates the very condition it is intended to cure.

*Nervous Energy.*—The establishment in modern times of laboratories for psychological and neurological research has been the means of throwing much light upon the nature of mental and nervous activity. Nervous energy no longer means, as formerly, an intangible, mysterious something, but, as has now been clearly demonstrated, is immediately and definitely connected with material elements found in the interior of the nerve cell. For example, a nerve cell, when in a state of rest, shows a large number of grayish granules, which have been shown to be intimately connected with the storage of energy; so that when the granules are abundant, the cell is like a fully charged battery, ready to discharge under the influence of the right sort of stimulus the maximum of energy which it is capable of exhibiting. On the other hand, when the cell is fatigued, as after prolonged, energetic work, the granules are found to be very few and small, and the cells shrunken and pale.

With these facts in mind, it is easy to understand why such disappointing results have followed the use of strychnia and a very large number of medicinal agents, so-called "nerve tonics," since it is evidently impossible that these drugs should in any way increase the store of energy in the cell; and the most that can be expected from them is the excite-

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ment of the cell to activity when it has become exhausted to such a degree that a sense of fatigue supervenes as a warning that the store of nervous energy is reduced to a point where any further demand upon it is dangerous, and the rest is imperatively demanded.

The only way that the energy granules of a cell can be augmented is by the assimilation of food from the blood, and the development of energy-containing particles. Cold water surpasses all other agents in its power to promote the normal energy-storing processes. Cold applications also facilitate to a very remarkable degree the discharge of nervous energy when a sufficient store exists, though sometimes it may not be available because its useful application is hindered by the influence of retained excretions of nerve-benumbing toxins generated within the tissues or absorbed from the alimentary canal. This effect of water is readily apparent in the influence of the cold bath upon muscular energy, to which attention is called elsewhere, and also in the sensation of well-being, buoyancy and readiness for exertion which results from the application of cold water.

The tonic effects of cold water are unquestionably to a large degree due to the influence of cold impressions acting through the nerves of the skin upon the sympathetic nerve centres. The great sympathetic nerve controls the blood vessels, glands, heart, the functions of secretion and excretion, and, in fact, all the vital functions of the body. The awakening of the sympathetic to renewed activity, or a balancing of its action, is what is specially needed by the great majority of chronic invalids. The functions of the brain and spinal cord, and through them all forms of nervous activity, are to a remarkable extent influenced by the sympathetic. The sensation of well-being which accompanies the reaction following a general cold application is largely due to the increased activity of the cerebral circulation, brought about through the stimulation of the sympathetic. By its powers to influence the sympathetic, hydrotherapy is capable of controlling, restraining, reorganizing, balancing, all the processes of organic life, and through them modifying the functions of animal life to a marvelous degree.

*Cold Water a Physiological Tonic.*—Cold water is a physiological tonic, and has the advantage over medicinal tonics of all sorts, in that it awakens nervous activity without the imposition of any extra burdens upon any vital organs, and without hampering the activity of any function. The cold bath employed in such a manner as to produce tonic effects accomplishes its results by increasing vital resistance

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to the causes of pathological processes, by making the wheels of life run more smoothly, by lifting the whole vital economy to a higher level. The impression made upon that harp of a million strings, the skin, with its vast network of sensory, motor, sympathetic, vasomotor and thermic nerves, arouses every nerve center, every sympathetic ganglion, every sensory and motor filament in the entire body to heightened life and activity. Every blood-vessel throbs and every cell quivers with a new life; the whole body thrills with quickened impulses; the whole being is translated into a new state of existence.

A person who has never experienced the glow of exhilaration, the invigoration and buoyancy of body and mind, which accompany the state of reaction from a short, general cold application, can not well appreciate the value or significance of the cold bath as a physiological stimulant. It is not too much to say that it is of all measures known to man the most valuable as a means of arousing to activity the flagging energies of the body, and lifting the enervated invalid out of the morasses and quagmires of chronic disease.—*Modern Medicine.*

## NAUSEA OF ANESTHESIA.

Nausea and vomiting following anesthetics is sometimes a distressing as well as dangerous condition, and it behooves us to avoid it as far as possible, not only for the comfort of the patient, but for the reason that in serious surgical interferences it may place life in peril.

Says the *Therapeutic Gazette:* "Blumfield, in the London *Lancet* of September 23, 1899, observes that some of the chief points to be attended to in the avoidance of after-sickness are: 1. Use as little of the anesthetic as possible consistent with perfect anesthesia. 2. Wash out the stomach at the close of the operation when much mucus has been swallowed. 3. In long operations, substitute chloroform for ether after three-quarters of an hour. 4. Move the patient about as little as possible during and after operation. 5. Place him on his right side in bed, with the head only slightly raised. 6. Give nothing but hot, thin liquids in small quantity for at least eight hours after. 7. Do not alter the temperature of the room for some hours. With proper attention to these points one-third of the patients operated on will be free from after-sickness, and for short operations the proportions will be much higher still. In fact, after all administrations up to twenty minutes, or not much longer, sickness will be found to be the exception."

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I have for some time given Ingluvin in liberal doses (10 to 20 grains) just prior to the anesthetic, and have been favorably impressed with its use, and would suggest its thorough trial by the profession.

Two cases are reported from the Hospital College of Medicine as follows:

Case No. 1.—Mrs. B., age 30, operated on for co nplete laceration of the perineum. She had twice before taken chloroform, and after each administration suffered from severe vomiting. She took 3 10-grain doses of Ingluvin six, four and two hours before the operation, and experienced almost no sickness after coming from under the anesthetic.

Case No. 2.—J. H., age 34, amputation at the hip joint. This man said he dreaded nothing but the chloroform, as at a previous operation he had suffered in a most distressing manner from that anesthetic. I directed the nurse to give him 10 grains of Ingluvin six and two hours before the operation. He vomited only once after coming from the table, and, though he suffered some considerable shock and much pain, had no complaint of nausea.

Dr. E. H. Gingrich, 511 Cumberland street, Lebanon, Pa., especially recommends Ingluvin for the vomiting so frequently experienced by patients coming out of anesthesia.

Prof. Hobart Amory Hare, in "Practical Therapeutics," writes:

1. "That chloroform or ether vomiting is probably centric."

2. "Upon the mucous membranes, ether as a liquid or in a vapor acts as an irritant, and causes, when its vapor is first inhaled, great irritation of the fauces and respiratory tract"

Ingluvin is valuable on account of its mildly depressing the sensitive nerves of the stomach, thus lessening the irritation of that organ. The vomiting centres are subdued, with the result that vomiting is controlled.

For vomiting succeeding anesthesia, Ingluvin should be given 20 grains one hour before the administration of ether or chloroform, and immediately after coming out of the anesthesia, one 20 grain powder; to be followed every hour by 5-grain powders, until vomiting ceases. Usually the 20-grain powder will be found effective. Ingluvin is a bland powder prepared from the gizzard of the chicken, and contains nothing which might contra-indicate its use in surgical operations as specified above.

It has long been used as a remedy to allay persistent vomiting of gestation with eminent success by many practitioners throughout the world. It therefore is not a new re

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paration, but simply an old remedy in a new capacity. Some months ago a professional suggestion was made to use it for the nausea of ether. Subsequent tests and their results have warranted its recommendation to the medical profession. Samples will be sent to any physician who wishes to test it in vomiting of anesthesia. Write W. R. Warner & Co., Philadelphia, for a sample.—*From Monthly Retrospect of Medicine and Pharmacy.*

## HABITUAL CONSTIPATION.

The treatment detailed is intended for habitual constipation. For the immediate unloading of the bowel one of the simplest and least harmful methods is the giving of one or more enemata of warm water, containing salt in the proportion of a teaspoonful to a pint. Soapy water may be used instead, if something stronger is needed. The amount to be injected varies with the age. For young babies one or two ounces is sufficient, and for those of two years, two or three time this amount. Either the hard-rubber syringe or the infant's syringe may be used. A useful injection consists of half a teaspoonful of glycerin in full strength. This is best given from a small hard-rubber syringe holding not more than half an ounce. The opening in the nozzle should be larger than ordinary, as the glycerin does not flow readily. If the mass in the bowel is large and hard, an injection of warm sweet-oil, retained some hours if possible, is better than anything else. It should be followed by an enema of soapy water. In some cases it is necessary to insert the finger or a small spoon-handle into the bowel and break up the masses carefully.

Glycerin suppositories—glycerin and soap—of a size for children are often excellent for opening the bowel. Gluten suppositories are also serviceable in many instances. A more economical plan is to employ little home-made suppositories of castile soap, or, in place of these, a soap stick, which can also be made at home, and which has the value of lasting for repeated usings. It consists of a smooth conical stick of firm castile soap two or more inches long, half an inch thick at the base, and tapering toward the other end to the thinness of about one-quarter of an inch. It should be greased with vaselin before using, inserted part way into the bowel and held there until a tendency to an evacuation shows itself.

If none of the methods described is effectual, laxative drugs must be employed. Their use, however, ought to be

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deferred as long as possible, and is much better left to a physician. Probably the best and least harmful of drugs is cascara in some form. There is made a cascara cordial which has a pleasant taste and is very effectual. Another very useful preparation is the syrup of senna, which is easily taken by children, as its taste is agreeable. Little sugar-coated pills, each containing one-tenth grain or less of aloin, are sometimes of service, one being given daily to a child of two years. A small quantity of manna, about five grains, can be given to a baby of six months once a day or oftener, dissolved in the milk, as its taste is sweet, or ten grains of phosphate of soda may be used in a similar manner. Magnesia or spiced syrup of rhubarb answers very well, but only for occasional use.—*Jour A. M. A.*

## CARE OF THE MOUTH.

Perhaps no part of the body is so often neglected as the mouth ; especially is this noticeable in the case of children. A mother who will religiously bathe her child and keep its body sweet and clean will often fail to cleanse its mouth. A new-born infant should have its mouth washed after each feeding ; a soft cloth wet in a weak solution of boracic acid should be used for this purpose. If this were always done we would rarely find a cause of infantile sore mouth.

After the teeth come and the mouth is large enough, a small, soft brush should be used ; the teeth and mouth should be thoroughly cleaned at least twice daily.

In illness where sordes and mucus accumulate rapidly, and where the tongue and lips are parched and stiff, attention is needed every hour ; the mouth should be kept moist, and the same treatment carried out through the night as during the day. Boracic acid solution, listerine, lemon juice, glycerine and distilled water are all refreshing, and soften the tissues ; where the lips are chapped or fissures appear, a lubricant of cold cream or sterilized vaseline should be applied. Where the gums are spongy or soft, and bleed readily, a few drops of tincture of myrrh added to pure water will help to harden them. Small squares of old linen or soft gauze should be used instead of a brush where one is ill or weak. These should be immediately burned after use.

Every part of the mouth should be cleansed ; behind the wisdom teeth, the roof of the mouth and under the tongue ; lemon juice and water will remove the fur from a thickly coated tongue. Where the teeth are sensitive the water used should be slightly warm.—*South Cal. Practitioner.*

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## BLACKHEADS.

Blackheads are not, as is generally thought, dust or dirt accumulated in the pores, but consist of fatty secretions of the skin and a coloring matter. The following mixture may be recommended for their removal :

℞ Kaolin, parts iv.
Glycerin, parts iij.
Acid acetic, parts ij.
Ol. odorat., ad lib.

M. Sig. Apply this mixture to the parts at night, and, if possible, also several times during the day. The blackheads will disappear when washed with this mixture and rubbed freely with a towel moistened with it, or can easily be removed after a few days.—*Tri-State Medical Journal.*

## ALCOHOL AND CYCLISM.

MM. L. Jacquet and Regnault (*Le Progrès Médical*, 29th July) believe that the prevailing popular belief that alcohol gives strength to the system is one of the causes of the prevalence of the increasing use of alcohol throughout the country. It is therefore the duty of physicians to combat this error, which they have heretofore contributed largely to spread among the people. We have had, they say, occasion to enquire of some well-known cyclists their opinion of the effects of alcohol from a professional point of view. Those consulted : Mr. Miller, of Chicago ; Calmettes and Goring, of Paris ; Monachon, of Geneva ; Fischer, of Mulhouse. Their reply was invariably the same ; they are all absolutely temperate, even when not engaged in active exercise they avoid aperitives and absinthe. As to their opinion of it during the race proper, it may be resumed in a single curt and emphatic formula : Alcohol weakens the limbs : "*L'alcohol coupe les jambes.*"

In the spring of 1888, during the severe snowstorm popularly known as the blizzard, the trains on the Long Island railroads were stopped, and the passengers to New York were obliged to endure cold and hunger, or walk several miles through the snow drifts. A young man, tall, slender, rather delicate, made one of the party who sought relief. When refreshment was found he absolutely refused alcoholic drinks in any form, and took a full cup of moderately strong coffee instead. Having found a place in which rest could be obtained, the most delicate of the party was the least exhausted after the prolonged and severe journey.

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Relying on his own experience he has since, much to his advantage, avoided alcohol and tobacco.

How many of the numerous accidents that are occurring daily are due to overstimulation? Investigation is due to the public.—*The Sanitarian.*

## THE X-RAYS IN DISEASES OF THE CHEST.

In the Boston *Medical and Surgical Journal* for January 18, Williams writes of the value of the X-ray examinations in the less frequent diseases of the chest illustrated by their use is those cases where aneurism is present or suspected.

He stated that aneurisms of the thoracic aorta may be seen by the X-rays before there are physical signs. This method of examination may give us greater assurance of the absence of an aneurism of the aorta in suspected cases than any other evidence that we can have.

He reports the examination of 34 cases, 15 having typical aneurisms, 6 had more or less dilatation of some portion of the arch, 1 showed an outline suggestive of aneurism, but there was no pulsation, and on autopsy a mass of glands was found. The remainder gave normal outlines in the region where an aneurism had been suspected.

In 13 of the 15 cases the aortic arch was the seat of the aneurism; in one of these there was a second aneurism in the innominate artery also; in the fourteenth case there were two aneurisms, one in the innominate and another in the subclavian artery; in the fifteenth case the aneurism was in the subclavian artery. Eleven of these cases were males and four females; 11 were between thirty-eight and forty-five years of age; two were thirty-three; one was forty-nine and one fifty-nine, and one twenty-nine. A syphilitic history was obtained in four cases. Pain was present in 12 cases and alteration of voice in 11. Laryngoscopical examination was made in 7 of these last cases, which showed paralysis of the vocal cord. The physical examination of 12 out of 14 of the cases of aortic aneurism was given in the hospital records; in five cases there were no physical signs of aneurism; in eight cases the heart was enlarged, and in five of these there were murmurs indicative of valvular defects, four of which were aortic and one mitral. Arteriosclerosis was found in the three cases in which an autopsy was made. No nephritis was found in any case.—*The Charlotte Medical Journal.*

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# SURGERY.

IN CHARGE OF

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## PRESERVATION OF SURGICAL NEEDLES.

At a recent meeting of the New York Surgical Society. Dr. Dawbarn recommended the use of a saturated solution of sodium carbonate (washing soda) in water, for the purpose of preserving surgical needles. He stated that in his opinion this method of keeping the needles and cutting instruments untarnished was superior to any other which had thus far come within his experience. He showed needles kept bright in this way for a year and more. Most of the other methods are open to some objection. Perhaps the most common method is to sew the needles into an oiled cloth, but this does not always prevent flecks of rust. As to keeping them in carbolized oil, this to some extent dulls the edge of the needles just as carbolic acid in watery solution does that of scalpels; lysol being a dark solution, the needles are not very easily seen in it ; calcium chloride in a closed place to keep the air dry, with the needles lying on a dish near it, produces a curious tarnish, almost like rust ; in Fuller's earth or other powders it is difficult to find the smaller needles ; in alcohol, unless it is absolute (and absolute alcohol ceases to be absolute very soon), the needles will finally rust. A solution of borax in water, as recommended by M. Maréchal, will also rust the needles as soon as the thin plating, which all needles have at first, becomes worn away from usage, exposing the steel beneath. Perhaps keeping needles in liquid petrolatum is almost as good a way as that under discussion ; its only objection being the unpleasant oiliness. Calcium chloride in absolute alcohol—thus keeping it absolute—is effective, but comparatively expensive. The same is true of placing a sheet of gelatin in the absolute alcohol, the gelatin by its affinity for water keeping the alcohol absolute. The method now advocated—washing soda dissolved in water to saturation—is inexpensive and satisfactory to the author.—*Gaillard's Medical Journal.*

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## DIRECTIONS FOR THE STERILIZATION OF CATHETERS AND BOUGIES.

Nicoll gives the following directions for the sterilization of catheters and bougies :

*Bougies*—Gum-elastic bougies will not bear heating to a temperature sufficient for sterilization. Soaking for fifteen minutes in carbolic acid solution 1 in 20, for half an hour in 1 in 40, or for an hour in perchloride of mercury 1 in 1,000, renders the surface so sticky that the towel adheres in the process of drying, and the bougie becomes covered with fluff. After several soakings the surface becomes permanently dull and sticky, and unfit for use. Dr. Schimmelbusch says that "a smooth bougie or catheter can mechanically be made externally free from germs by rubbing it with a piece of sterilized gauze and warm water." To test this a series of six gum-elastic bougies in use from six to eighteen months, after being employed in cases of stricture, were washed with tepid water and soap, rinsed in cold running water, and dried with thorough light friction with sterilized gauze. They were then rubbed on the surface of acid and alkaline agar tubes. In one case colonies of an unidentified coccus appeared, in another a patch of penicillium. The other ten tubes remained sterile. Six bougies soiled with pus were similarly treated; all the tubes remained sterile. In other experiments, instead of the gauze, an ordinary towel fresh from the laundry was used, and similar results were obtained. It appears, therefore, that antiseptic solutions which rapidly destroy instruments are unnecessary for sterilization.

*Catheters.*—Red rubber catheters (Jacques) may be sterilized by boiling or steaming, or may be soaked for months in carbolic solution (1 in 20) or perchloride of mercury (1 in 1,000) without damage. A rubber catheter may be used daily for six months without becoming unfit for use, if washed every day with hot water and soap, and put to soak in carbolic lotion for the remainder of the twenty-four hours. But there are certain red rubber catheters which rapidly deteriorate under repeated boiling, and all rubber catheters ultimately do so. Prolonged and repeated soakings in antiseptics have little effect. By experiments the writer has proved that rubber catheters, boiled, steamed, or soaked for four hours in the lotions mentioned are rendered sterile internally and externally. But gum-elastic catheters, like bougies, will not stand the lengthened and repeated soaking necessary for sterilization. There is no entirely reliable method. For practice the writer has formulated the following rules :

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(1) Avoid as far as possible the employment of catheters. In cases of stricture it can only be very exceptionally that a catheter is called for. Bougies, which are readily sterilized, will do all that is necessary. (2) Where a catheter must be employed, u e where possible a red rubber Jacques' catheter in preference to a gum-elastic. In retention from atony spinal paralysis, reflex nervous effects, and other causes, and in many cases of prostatic retention, the former answers as well, and is as readily sterilized by boiling or immersion in an antiseptic solution as is a metal catheter. (3) Where the red rubber fails to pass, the use of metal catheters, epecially by the patient, does not commend itself as free from risk of injury. Gum-elastic catheters must therefore be used. If the urine is very septic the writer destroys the catheters used. If the urine is not very purulent or offensive, he washes the catheters externally with soap and water, and then with antiseptic solutions, which is followed by internal steaming. Those that survive he retains. When the regular use of a gum-elastic catheter is necessary, the patient is supplied with a catheter with a well-finished interior. After use he thoroughly washes it, holds it under the tap for a few minutes, and lays it asides in boric acid, weak perchloride, or other weak antiseptic. This only offers a reasonable chance of asepsis, but it is useless to expect an average patient to carry out more elaborate plans. The writer has had glass tubes constructed, which are filled with the antiseptic solution, in which the catheter is placed after use. The solution varies in strength according to the kind of catheter; for gum-elastic catheters it must be weak; red rubber catheters will stand anything.—*Gaillard's Medical Journal.*

## A NEW "T" BANDAGE.

W. O. GREEN, Louisville, Ky., employs a simple device for holding dressings in place about the anal region. This bandage is always the proper length, because it is not made until applied. It is necessary to employ heavy, thick material, the heaviest unbleached cotton being the best adapted. This is cut into strips not less than four inches wide; the average length for each bandage is two yards. About six inches of the bandage is unrolled, and folded upon itself three inches from the end. In the centre of the fold a cut is made with a pair of scissors. In consequence of the fold, the cut should be made only one-half the desired length when unfolded, and the limit of the cut at the centre point should be at least an inch from the free end of the bandage. This

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will be about half an inch or more than the diameter of the roller. The bandage is passed around the waist, the one end brought through the cut, which is placed in the centre of the back. This obviates the use of pins, buttons or knots, and at the same time the waist and perineal bands can be made to conform to the parts. The perineal band is passed up and under the waist band in front, where it is tied in the form of a reinforced bow-knot, and the roller cut off after the knot is tied. For the first dressing subsequent to rectal operations this bandage is not employed, because sufficient pressure cannot be brought to bear to give firm support to the anal region, but it has been employed almost exclusively for holding in place rectal dressings, and can be used with equal efficiency for genito-urinary and other perineal dressings. —*N. Y. Med. Record, Medical Review.*

## A TREATMENT FOR ACUTE SEROUS SYNOVITIS PERMITTING OF JOINT FUNCTIONS.

The method might be called the compression treatment. It has proved far more satisfactory than the old ones of rest and immobilization, hot or cold packs, evaporating lotion, etc. Its application is quite simple, though considerable care and judgment should be exercised. The principle is to fill all depressions about the joint with cotton, and then to apply strips of rubber adhesive plaster in such a way as to entirely encircle the joint and several inches of the limb above and below it, so as to make firm and equable compression. The joint in which it has been found to be of the greatest value, and in which the results, both immediate and permanent, are truly remarkable, is the knee. One of these cases treated by this method is detailed, showing exactly the mode of procedure. The chief advantages of this dressing are its small weight, the immediate relief from pain that it affords, and that it permits the joint functions—motion and weight-bearing—without injury. A number of patients were doing hard labor a day or two after the dressing was adjusted to an acutely inflamed knee-joint. As a rule, the patients are permitted to use the limb in any way that does not cause pain or discomfort. We are indebted to the sprain treatment for the suggestion of adhesive plaster as a joint support ; but it had not been employed in the treatment of caute serous synovitis previous to the first publication on this method by Hoffmann in 1895.—*Dr. P. Hoffmann, N. Y. Med. Jour., Med. Review.*

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## CELLULOID YARN; A NEW MATERIAL FOR SUTURES AND LIGATURES.

J. PAGENSTECHER reports, in the Philadelphia *Medical Journal*, the brilliant results from the use of linen thread which has been impregnated with a solution of celluloid. For a few years he has used this new material exclusively for all purposes, and has found it superior to all others, whether used only for skin sutures, internal sutures on the bowels or the bladder, for uniting the capsule of joints, or even to sew up the torn ligamenta cruciata. In all these cases this material has proven to be the best that has been used. The sterilized yarn shows its good properties when dry, but any remnants may be kept in good condition in alcoholic sublimate. It can be sterilized with the bandages in steaming vapor. By impregnation with celluloid the yarn acquires great firmness and resistance: the surface is smooth and brilliant, and its tendency to absorb pus and other secretions from wounds has comparatively ceased. Therefore the thread does not expand or unravel; knots hold with absolute security. As the strength of the thread is increased by the addition of the celluloid, and is much greater than that of silk, finer threads can be used, which will not break while being knotted. Another advantage lies in the fact that it is more readily handled, especially while threading the needle, as the new thread is rigid and easy to control.—*Medical Review.*

## THE USE AND ABUSE OF POULTICES.

S. E. EARP, Indianapolis, believes that much harm results from the use of a poultice because proper instructions are not given to patients, and they remain in ignorance as to what is to be expected from its use. As a rule, the poultice should be non-irritating, it should be used hot and renewed often. Its virtue depends on the heat and moisture, and hence it is of little importance whether it consists of flaxseed meal, cornmeal, etc., except so far as these are capable of retaining the heat, and the selection is a matter of convenience. The statement of many that the antiseptic solution has superseded the poultice in the treatment of open wounds is somewhat misleading, and should not be a reflection on the latter from the fact that poultices were frequently used when they should not have been. The benefits of the poultice as such, or as a medium, are thus summarized: 1. To relieve congestion. 2. To reduce inflammation. 3. To promote absorption, favor resolution, or hasten suppuration. 4. To diminish

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tension. 5. To soften incrustations. 6. To encourage tissue relaxation. 7. To stimulate healthy granulations. 8. To perform the office of a deodorant and, in a sense, of an antiseptic.—*N. Y. Med. Jour., Med. Rev.*

## GERMICIDE FOR THE GONOCOCCUS.

The latest thing which is vouched for as a sure destroyer of the gonococcus is picric acid. It is claimed by those who have used this method that it exerts almost a specific action in chronic urethritis. In using the remedy, a solution of from 1 to 2 per cent. is employed, and it is always used by instillation. The soft or hard catheter is introduced into the urethra as far as the cut-off muscle, and the injection is slowly made until the fluid flows from the anterior urethra. It is claimed that many cases have yielded to this treatment that have resisted protargol, nitrate of silver, and permanganate of potassium.—*Medical Review.*

## LUBRICATION OF THE CATHETER.

A wholly satisfactory lubricant for catheters has not been devised. These instruments, which should be aseptic, are with difficulty rendered so, and it is still more difficult to keep them so. The problem of lubricating them, and at the same time avoiding infection, is difficult to solve. One of the latest recommendations for this purpose is that of Kraus, who uses a paste composed of tragacanth, 2.5 parts, glycerin, 10 parts, and a 3-per-cent. solution of phenol (carbolic acid), 90 parts. This, he claims, is an admirable lubricant, is easily removed by warm water, and is aseptic.—*Medical Review.*

## SPRAINS.

The Gibney treatment of sprained ankle is described as follows: Ordinary adhesive plaster is cut into strips one-half-inch wide and in two lengths—twelve and eighteen inches. As soon as the patient is seen, one of the longer strips is placed around the ankle parallel to the sole of the foot. Beginning in front of the big toe, the strip is carried around the ankle just above the contour of the sole, and the end is brought back across the top of the foot to about the point where the strip began. It is well to place, overlapping this initial strip, a parallel piece. These strips should be drawn as tightly as possible. Next, another strip should be placed at right angles to them, which makes it run parallel

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to the back of the leg. One of the shorter strips should be selected for this purpose. Beginning well behind and above the ankle, this strip should be carried down around the sole of the foot and brought up on the other side of the leg, making, as it were, a stirrup for the foot. This strip is closely applied. Now the strips should be applied alternately, first one around the ankle parallel to the sole, and then one parallel to the back of the leg, each one overlapping the one previously applied, running in the same direction to some extent, until the entire foot is enclosed in a boot of adhesive plaster, having the appearance of a shoe in which part of the heel has been cut away. Over this dressing is now placed an ordinary roller bandage. The patient should be careful for a day or two, when he can begin to move around rather freely. This dressing should be kept on until the pain and swelling have subsided. If the dressing becomes loose it can be reinforced by additional strips placed over the loose ones.—*J. H. Adams, in Railway Surgeon.*

## REMOVAL CF EAR WAX.

Hardened wax in the external ear can often be removed readily by injections of warm water and soap, soda or ammonia. Many cases resist this, and require the softening effects of glycerin or sweet-oil for a day or two before syringing. Do not bother with these long processes, but use a half-strength solution of hydrogen dioxid in the ear for about five or ten minutes. This will disintegrate the hardest plugs, and they can be removed with very little syringing. I have yet to see the case in which this process has caused irritation or inflammation. Do not use too much force with the syringe. Wipe the ear perfectly dry with absorbent cotton and apply petrolatum. Wear a small plug of cotton in the ear for one day after removal.—*Phila. Med. Jour.*

## EPISTAXIS.

*Treatment.*—All that is necessary in epistaxis is to fashion with a pair of scissors a dry plug of prepared sponge, in size and length comparable with the little finger of a twelve-year-old boy. This should be carefully soaked in boiled water, to free it from grit, squeezed dry to free it from unnecessary fluid, and inserted its full length, gently, along the floor of the bleeding nostril. No

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styptic is necessary. The expansive pressure of the soft sponge against the bleeding side, increased by the coagulation of a few drops of blood in its interstices, will check the bleeding at once. It should be removed in twelve hours; under no circumstances should it remain longer than twenty-four.—*Sajou's Cyclo.*

## BURNS AND SCALDS.

*Treatment.*—According to E. T. Milligan, burns, when under treatment, should be exposed as little as possible by changing dressings. Morphine should be used hypodermically for pain, and tincture of musk by the mouth as a cardiac stimulant. The latter seems to control shock, due to injury. In burns of the first degree an ointment containing a sedative or carron-oil can be applied with advantage. In burns of the second or third degree picric acid in solution (5 to 1,000) is an excellent application, but a dry dressing is personally favored. A powder containing 2½ drachms of pulverized camphor and 1 ounce each of prepared chalk and magnesium sulphate is one of the best. When powders are used the injured parts should be covered with oiled silk to keep the dressing from becoming entangled in the injured parts. When prostration is great, a saline infusion is of marked value.

Ellice M. Alger has found that the combination of picric and citric acids, which Esbach long ago devised for the detection of albumin, is more effective than the picric acid alone, in burns of the second degree.

Esbach's solution consists of 10 parts of picric acid, 20 of citric acid and 1,000 of water. Without any elaborate attempts at antisepsis the bullæ and vesicles should be opened with a clean blade and the fluid applied freely, care being taken that the solution reaches the interior of each one. The combination after the first smart has passed removes the pain very quickly. After the excess of fluid has drained off the part may be covered with rubber tissue or soft gauze, and left undisturbed for several days. After two or three days the fluid should be reapplied to such areas as are moist, and the part carefully recovered.

R. H. Gay has obtained good results from using the following in burns and scalds: 1 pound of mutton-tallow, 1 drachm of English resin and 1 drachm of bees-wax should be put into a vessel, perfectly free from grease or other substance, over a slow fire. After the ingredients are melted and thoroughly mixed, they are to be removed from the fire

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and ½ pint of linseed-oil (linum usitatissimum) is to be added, stirring until cool to prevent separation. A few minims may be dropped on a smooth surface to cool, to see whether it is of the right consistency or not. If too soft, tallow should be added; if too hard, oil. It is now ready to pour off into boxes for use. The directions for using are to spread it on old linen or cotton cloth, to a sufficient thickness, large enough to cover the burn or scald, and to renew daily. This preparation is cooling, detergent and healing, and if instantly applied to burns and scalds will almost immediately stop the pain and prevent blistering.

In the treatment of scalds and burns Edward Roelig finds aristol of great service. After a thorough disinfection and cleansing of the burned area, and the opening of the vesicles, a dressing of aristol salve smeared upon sterilized gauze in a layer of about the thickness of a knife-blade is applied, and this dressing changed daily. The dressing is covered with cotton and held in place with gauze bandages. Granulation and cicatrization occur promptly. In personal cases, at first an aristol salve, consisting of 1¼ drachms; ol. olivar., 2½ drachms; lanolin, 10 drachms, was applied, and, when the wound surface had become smaller and granulations had formed, aristol powder was dusted on, and covered with gauze and cotton.

Vehmeyer has used with good results an ointment containing fluorin, and sold under the name of "Epidermin," in the treatment of severe burns and scalds. It should be renewed twice a day. Relief of pain, prevention of profuse suppuration and rapid growth of any islets of undestroyed epidermis are its great advantages.

Naftalan has been found by Richard Bloch to so fully meet the therapeutic indications demanded in burns, whether caused by hot fluids, steam or heated solids, etc., as to be almost a specific.

The use of saline transfusion for burns and shock is recommended in an editorial, which states that, even if the toxæmic condition is not directly improved by the saline injections into the subcutaneous tissues of veins, there is still another one in which this method of treatment may be of great good, in that surgical shock is nearly always present as a result of severe burns and scalds. In shock a condition of profound relaxation of the blood-vessels exists, so that arterial pressure is very low and the vital centres are not properly supplied with blood.

While intravenous injection does not necessarily raise blood-pressure, this method of treatment is capable of read-

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justing the circulation to such an extent that the evil manifestations of vasomotor paralysis are set aside. It seems, therefore, that, in treating cases of severe burns or scalds, this method of procedure should not be ignored, but should be actively employed.

Patel notes the case of a child, aged 2½ years, who had a burn of the second degree, involving, more or less, both arms and legs, face and trunk. The general condition was bad, the pulse imperceptible and the child unconscious. Caffeine, alcohol, bouillon and milk were given. On the third day 250 cubic centimetres of saline solution were injected, and on the fourth day the child became for the first time conscious. Between the fourth and twenty-second days six similar injections were given. Until the twentieth day he improved in every respect, but on the twenty-second his general condition was not so favorable, and on the twenty-fourth day he died. At the necropsy the lungs alone presented appreciable lesion: diffuse catarrhal pneumonia. The great improvement after the first four injections and the survival of the child for nearly a month seemed to be due to the serum. The cause of death in extensive burns is thought to be due to an autointoxication. Consequently, once the period of shock is passed, the treatment should be directed to freeing the system of the circulating toxin, and for this saline injections answer well. Due attention should also be paid to the emunctories, so as to still further favor the elimination of toxins.

Azzarello divides the theories of the cause of death from burns into four classes: (1) death from shock or extreme pain; (2) embolism, thrombosis and destruction of the blood-elements; (3) pyæmic infection through the burnt surface; (4) poisons formed by the action of heat on the tissues or autointoxication from deficient excretion by the skin. By experimenting upon dogs and rabbits, it is personally claimed that the intoxication theory is the correct one. Injection of large quantities of artificial blood-serum subcutaneously appeared to save life in several cases.—*Monthly Cyclopædia of Practical Medicine.*

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# Jottings.

THE TRUE VALUE OF GARGLING.—By gargling in the usual way only the upper anterior surface of the uvula and soft palate and base of the tongue are reached. The method of holding the nose and throwing the head well back when gargling enables the fluid to reach every surface of the pharynx. The value of the two methods can readily be tested by painting the posterior wall of the pharynx with a strong solution of methylene blue. After gargling with water in the usual way, the latter will be perfectly clear and unstained; then let the patient gargle again by the method suggested, and the ejected fluid will be found stained.—*Editorial, Charlotte Medical Journal.*

HOW TO USE EYE DROPS.—A suggestion as to how to put drops in an eye may be of service. Have the patient lie down or sit in a reclining chair, with head thrown back and eyes closed. Drop the medicine on the closed lids, allow it to remain until it becomes heated from contact with the skin, then open the lids gently and allow it to flood the eyes. In the case of children particularly will this be found to make the work easy.—*Alkaloidal Clinic.*

REMOVING EAR WAX.—The Western *Clinical Recorder* says that cerumen may be quickly and effectually softened by filling the meatus with peroxide of hydrogen and allowing it to soak for a few moments, after which it may be easily removed by syringing with warm water.

POULTICES IN BRONCHITIS AND BRONCHO-PNEUMONIA IN CHILDREN.—A. W. Senior states that poulticing of the chest in bronchitis and broncho pneumonia is unscientific and prejudicial to the welfare of the patient. The difference in the temperature of the poultice when applied and when removed is such that one might as well be continually removing the child from a warm room out into the cold every few hours. The weight of the poultice must also be taken into consideration. The disadvantages of poultices more than counteract any beneficial influences they may have—*British Med. Journal.*

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The diagnosis of scarlet fever is not always easy, and Lindsay (*British Med. Journal*) has very well summarized the main points to be borne in mind. These are:

1. Initial vomiting, very constant in children under ten, less so above that age, and rare in measles, German measles and diphtheria.

2. Undue frequency of pulse—say 140 to 150—out of proportion to the other symptoms.

3. The rash, beginning on the upper part of the chest, over the clavicles and about the flexures of the neck; often well marked on the back of the waist.

To discriminate between scarlatina and German measles, Lindsay is in the habit of relying upon the following points: In scarlatina there is initial vomiting; a brief but well marked prodromal stage, with vomiting, chills, headache and sore throat, sometimes going on to ulceration; no early enlargement of post-cervical glands. In German measles there is no vomiting, no prodromal stage, the rash being often the first symptom, and always appearing on the face; little or no constitutional symptoms; no ulceration of the throat; a very characteristic early enlargement of the post-cervical glands.

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FOREIGN BODIES IN THE EAR.—Hummel (*Munch. Med. Woch.; Am. Jour. Med. Sci.*) makes the following deductions:

1. The relation of the normal ear canal to inanimate foreign bodies is entirely without reaction; that is, the foreign body in the ear does not, *per se*, endanger the integrity of the ear.

2. Every hasty endeavor at removal is, therefore, not only unnecessary, but can become very injurious.

3. In all cases not previously interfered with (with few exceptions), the foreign substance can be removed from the ear by means of syringing.

4. The general practitioner should never employ anything but the syringe in his endeavors at removal of foreign bodies from the external auditory canal.

5. An instrumental removal of a foreign body from the ear should be effected only by one fully able to examine the ear with an otoscope and acquainted with every operative manipulation in this region.

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PRACTICAL HINTS REGARDING CHILDREN.—Always teach a nurse that a child cannot swallow as long as the spoon is between the teeth; that it is advisable to de-

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press the tongue a brief moment and withdraw the spoon at once, and that now and then a momentary depression of the nose is a good adjuvant.

The taste of quinine is disguised by coffee, chocolate and "elixir simplex."

Powders must be thoroughly moistened; unless they be so the powder adhering to the fauces is apt to produce vomiting.

Inunctions require a clean surface, and are best made where the epidermis is thin, and the net of lymph-ducts very extensive, as on the inner aspect of the forearm and the thigh.

Babies, after having taken opiates for some time, demand larger, and sometimes quite large, doses to yield a sufficient effect.

Febrifuges and cardiac tonics, such as quinine, antipyrine, digitalis, strophanthus, sparteine, convallaria, etc., are tolerated and demanded by infants and children in larger doses than the ages of the patients would appear to justify.

Mercurials affect the gums very much less in young than in advanced age.

The rectum of the young is straight, the sacrum but little concave, the sphincter ani feeble, and self-control is developed but gradually; for these reasons rectal injection is allowed to flow out or is vehemently expelled. Therefore, one which is expected to be retained must not irritate. The blandest and mildest is a solution of six or seven parts of chloride of sodium in a thousand parts of water, which serves as a good vehicle for medicine unless incompatible with the latter. The injection must be made while the child is lying on its side (preferably the left side), not on the belly over the lap of the nurse, for in this position the space inside the narrow infantile pelvis is reduced to nothing.

In many cases of intense intestinal catarrh, large and hot (100° to 108° F.) enemata will relieve the irritability of the bowels and contribute to recovery. They must be repeated several times daily, When there are many stools, and these complicated with tenesmus, an injection, tepid or hot, must or may be made after every defecation, and will speedily relieve tenesmus.—PROF. JACOBI, in *Pacific Med. Jour.*

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THE
# CANADA MEDICAL RECORD
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# Editorial.

## SURGEON-CAPTAIN FISET.

The many friends of the Hon. Dr. Fiset will read with great pleasure the following extract from the report of Lieut.-Col. Otter, Commanding the 2nd Battalion Royal Canadian Infantry, on the Battle, which is now nominated "Paardeberg":

"The company stretcher-bearers exhibited great pluck, and five of them were among the wounded. Three of them were wounded in conveying Captain Arnold from the firing line, the stretcher upon which he was being made a special object of attention by the Boer marksmen. In connection with this incident I must note the courage displayed by Surgeon-Captain Fiset, who, when the stretcher upon which Captain Arnold was being brought to the rear, was stopped a short distance from the firing line by the wounding of one of the bearers, went forward and attended to Captain Arnold, and subsequently assisted as a bearer in bringing him to the rear. Captain Fiset also attended to many others wounded, under fire during the day."

## THE ROYAL ARMY MEDICAL CORPS.

In connection with our article in the March number of

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the RECORD on "Medical Officers of the Canadian Militia," we direct the attention of our readers to the following extract from the *British Medical Journal* of 17th March, headed, "The Undermanning of the Army Medical Service":

Compared with the February list, the total has decreased by 4, accounted for as follows in the obituary: 1 murdered on Burmah-Chinese frontier, 1 died of wounds and 2 from disease in South Africa.

The number at home has sunk from 117 to 75, no doubt through the mobilization of the Eighth Division, while the number in South Africa has correspondingly increased from 350 to 389. The number at other foreign stations is 386, against 385, while the unposted have declined from 6 to 4.

It must be noted that if the administrative and the executive officers holding staff appointments, and therefore not available for general duty, be deducted from the 75 at home, only about 50 full-pay executive medical officers are left for general duty. These are reinforced by about 84 retired-pay officers, called "acting" in the Estimates, and by 33 on the retired list "temporarily employed" (of whom 2 are in South Africa), and by a large contingent of civilian surgeons, of which there is no complete return.

The effective total strength of full-pay army medical officers is nominally at present 854, not including the Director-General, but if 16 seconded officers be deducted the real strength is 838. This number is insufficient for ordinary peace duties, and, of course, quite unequal for the present strain. It provides no margin whatever for current casualties and periodical reliefs; it will be still more insufficient when the proposed addition of 27,600 men to permanent army establishments is effected. The present number of 838 officers must indeed be reinforced by at least 200 if the service is to be placed on an efficient footing.

## DAMAGES CLAIMED FOR ANTENATAL INJURIES.

According to the New York *Medical Record*, the Supreme Court of Illinois has recently adjudicated in a remarkable case. An infant claimed damages for a deformity alleged to have resulted from injury to the mother before its birth. The mother, while pregnant, was injured in an

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elevator accident at St. Luke's Hospital, Chicago, her left leg being caught and crushed. When the child was born his left leg was deformed. The hospital anthorities settled with the woman for her injuries, and then she brought suit in the child's name for 50,000 dollars damages for the deformity, which it was claimed was due to the same accident. The Court dismissed the suit on the ground that at the time of the accident the child could not be credited as a separate being capable of sustaining an action independent of the mother.

The British *Medical Journal* of March 17 states that Dr. William Osler, now Professor of Medicine in Johns Hopkins University, Baltimore, has sent in an application for vacant chair of the Practice of Physic in the University of Edinburgh. Dr. Osler's many friends not only in Montreal, but throughout Canada, will wish him success. There are three other candidates, all of whom are graduates of the University of Edinburgh.

At a largely attended meeting of the profession in Ottawa a short time ago, it was decided to hold the meeting of the Canadian Medical Association on the 12th, 13th and 14th of September 1900. The meeting was unanimous in the desire to make the Century gathering of the Association the best meeting ever held. A large sum of money was subscribed by those present for the entertainment of visiting members, making it a certainty that those in attendance will have, if possible, even a better time than they have ever before had in the Capital City.

The President, Dr. R. W. Powell of Ottawa, has recently heard from Mr. Edmund Owen of London, England, the gratifying information that he will deliver the Address in Surgery. This in itself should assure a large attendance.

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# Book Reviews.

**A Pocket Medical Dictionary**, giving the pronunciation and definition of the principal words used in medicine and the collateral sciences. By George M. Gould, A.M., M.D. Fourth edition revised and enlarged, 30,000 words. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut street, 1900. Price, $1.

This little book can justly claim to be a "Multum in Parvo," for within its very limited size is contained a vast amount of practical information briefly put. An author who can say, as Dr. Gould does, that the total circulation of his dictionaries has passed the one hundred thousand mark, must feel that his efforts have filled a long-felt want in the medical profession, and such popularity should be very encouraging to him. Since the publication of the last edition of this little work the author has been able to find an unexpectedly large number of eponymic clinical terms not previously included, and in order to insert them the table itself has been rewritten and greatly increased in size. The Dose Table has also been enlarged by the inclusion of the names and doses of drugs recently introduced. To medical students this little book will be invaluable, as it may be carried in the pocket and be available for hurried reference, and to serve as a passing reminder of the essential meanings of the more commonly used terms. The binding and general "get up" of the book is excellent, and the price ($1) brings it within the reach of all. R. C.

**International Clinics.** A quarterly of clinical lectures on Medicine, Neurology, Surgery, Gynæcology, Obstetrics, Ophthalmology, Laryngology, Pharyngology, Rhinology, Otology and Dermatology, and specially prepared articles on treatment and drugs by professors and lecturers in the leading medical colleges of the United States, Germany, Austria, France, Great Britain and Canada. Edited by Judson Daland, M.D. (University of Pennsylvania), Philadelphia, Instructor in Clinical Medicine in the University of Pennsylvania; Professor of Clinical Medicine in the Philadelphia Polyclinic, etc. Volume IV., Ninth Series, 1900. J. B. Lippincott Co., Philadelphia.

The present volume contains thirty-seven articles on different subjects, and many of great interest. Among remedial agents discussed are papers on Rest, a Rational Therapeutic Agent in the Treatment of Dilatation and Dislocation of the Stomach, by C. D. Spivak, M.D., and Hydrotherapy in the Homes of the Poor, by Alfred C. Haven, M.D. The latter discusses the advantages of water treatment at the homes of patients, and describes a very convenient form of portable bath, the use of which obviates some of the difficulties of carrying out this treatment where a trained nurse is

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not available, and other facilities limited. Among articles on treatment are: The Treatment of Pneumonia by Hypodermoclysis, by Frederick P. Henry, M.D.; Albuminuria in High Altitudes and its Treatment, by Edward C. Hill, M.S., M.D.; Treatment of the heart in Chronic Interstitial Nephritis, by Arthur R. Elliott, M.D. In medicine, Morbid Proclivities or Diathesis, by Sir Dyce Duckworth, M.D., LL.D.; Bronchial Asthma, by Frederick Müller, M.D.; Specific Disease of Liver, by George T. Cole, M.D.; The Necessity of Medical Attention to Abdominal Cases requiring Surgery, by A. L. Benedict, M.D.; The Time of Heart Murmurs and the Significance of the Apex Beat, by Prof. Martius; Cerebral Apoplexy, by Prof. Emanuel Mundel, M.D. Other interesting papers are those by Carl Beck, M.D., H. P. Newman, A.M., M.D., E. Fletcher Ingals, M.D., and Prof. H. Hallopean.

J. B. McC.

# PUBLISHERS DEPARTMENT.

## SANMETTO IN CHRONIC ORCHITIS.

J. A. Stothart, M. D., Savannah, Ga., reports the following case: "During November, 1898, a Greek fruit vender called at my office, suffering with chronic orchitis. The patient stated that the first attack occurred four years prior to this time. During the four years there had never been more than two and a half months between the attacks. He had been under treatment most of this time, and several times in the hospitals, and had been discharged as cured by several physicians. The testicle had almost arrived at the condition of ossification, but at no time had there been any pus formation. I prescribed Sanmetto, and directed that the treatment be continued for two or three months. My treatment was carried out to the letter, and there has never been any return of the trouble since beginning the use of Sanmetto. I have used Sanmetto in other urethral troubles with very satisfactory results."

## LITERARY NOTES.

People who want to read Augustine Birrell's delightful address on the question, "Is it Possible to Tell a Good Book from a Bad One?" will find it in full in *The Living Age* for April 14. It is full of humorous and chastening reflections.

"John England's Outgoing," the short serial now running in *The Living Age*, is a story of Georgian days, told with singular delicacy and quaintness.

Lady Broome's "Bird Notes" in *The Living Age* for April 21, and the *Quarterly Review's* paper on The Wild Garden, which forms the leading article of the same number, are charming and seasonable.

Peter Rosegger's story, "The Seal of Confession," published in *The Living Age* for April 21, in a translation by Dr. Hasket Derby, is a striking study of the workings of conscience, and a conflict of moral duties.

The facts in that present day tragedy, the political obliteration of Finland, are compactly but forcibly presented by Mr. J. Westlake, in an article which *The Living Age* of April 21 reprints from *The National Review*.

*The Living Age* for April 28 will print the hitherto unpublished letters between Thomas Carlyle and Robert Chambers, which first saw the light in a recent number of *Chambers's Journal*. In the same number of the magazine, A. T. Quiller-Couch discourses feelingly upon The Tragedy of the Minor Poet.

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CANADA
MEDICAL RECORD

MAY, 1900

# Original Communications.

## THE REMOVAL OF THE FIBROID UTERUS BY THE ABDOMEN, WITH REPORT OF TEN SUCCESSFUL CASES.*

(*Author's Abstract.*)

By A. LAPTHORN SMITH, B.A, M.D., M.R.C.S., ENG.,

Fellow of the American and British Gynecological Societies; Professor of Clinical Gynecology in Bishop's University; Gynecologist to the Montreal Dispensary; Consulting Gynecologist to the Women's Hospital; Surgeon-in-Chief of the Samaritan Free Hospital for Women; Surgeon to the Western Hospital, Montreal, Canada.

Twenty years ago he was strongly opposed to operative treatment of fibroids on account of the high mortality then prevailing among the best operators. Ten years ago he became a strong advocate of Apostoli's method of electrical treatment by which he had cured the hemorrhage permanently in sixty-three out of a hundred and two cases in ten years. Eight years ago Price lowered the mortality enough to induce him to operate in certain cases with the serre noeud. Baer farther reduced the mortality, and he adopted his method and operated oftener. Three years ago Pryor perfected an ideal method which has almost no mortality, and which he (Lapthorn Smith) had adopted, and to which he gave the preference over all other treatment in every case of fibroid suffering enough to consult him. He claimed that he had acted consistently throughout, being guided by the one test question, "What is the mortality?" In his last ten successive cases, seven last year and three this year, all had recovered. Therefore the operation

*Read before the American Gynecological Society at Washington, May 1, 1900.

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was now almost devoid of danger, while it was absolutely effective. Pryor's method is by far the best, and to it the author believed was due the absence of mortality in these ten cases. The great advantage of Pryor's method is that we begin on the easy side, and, after securely tieing the ovarian, round ligament and uterine arteries, and separating the bladder, we cut across the cervix and roll the tumor out, thus obtaining plenty of room to tie the arteries from below upwards. Another great advantage of this method is that there is much less danger of injuring the ureters. This accident is most likely to happen on the most difficult side, that is the side where the tumor fills all the space between the uterus and the wall of the pelvis. But it is precisely on this side that the tumor is dragged away from the ureter while it is being rolled out, and, by the time that it becomes necessary to cut anything on that side, the ureter is at least two inches away and quite out of danger. Doyen's method has this advantage on both sides, because he pulls the tumor off the bladder and ureters, and from the first cut he is getting farther and farther away from the bladder and ureters. But Doyen's has the grave objection of opening the vagina, and thereby increasing the time of anesthesia, the loss of blood and the risk of infection, besides the aesthetic one of shortening the vagina. The author lays even greater stress than Pryor does upon the importance of feeling for each individual artery, and tieing it before cutting, and then putting a second ligature on it, as the first one may loosen after the tension of the tumor has been removed. He also strongly advises chromicised catgut prepared by each operator himself, or else red cross cumol catgut prepared by Johnson, of New Brunswick, N.J., which he has found reliable. Besides the six principal arteries there are two small arteries which require tieing on each side of the cervix. There is no need of disinfecting the stump beyond wiping away the little plug of mucus; but the cervix should be hollowed out so as to make anterior and posterior flaps which are securely brought together before sewing up the peritoneum. The omentum, if long enough, should be brought down to meet this line of suture, thereby preventing the intestine from sticking to it or to the abdominal incision,

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The author is opposed to leaving the ovaries and tubes, although he admits that in young women by so doing the discomfort of the premature menopause is avoided. But in the majority of cases the appendages are diseased, and we run the risk of the whole success of the operation being marred by leaving in organs which will sooner or later cause more symptoms than did the fibroid itself. His experience of leaving in ovaries, or portions of ovaries, has been most unfortunate, having received no thanks for his conscientious endeavors, but a great deal of blame for having failed to cure the pain, which, in the patient's estimation, was much more important than the tumor.

He was also much opposed to myomectomy; the operation was quite as dangerous as hysterectomy; there was very seldom any reason for it, most of the women who have fibroids being unmarried or at an age too advanced to raise children to advantage or having passed the child-bearing age altogether. After submitting to such serious operation the patient had a right to be guaranteed against a second or a third one for the same disease. So many women have been disappointed by these incomplete or so called conservative operations that their friends who really could be cured by an operation hesitate to undergo it. He would make an exception of course in case of there being apparently only a single polypus no matter how large or a single pediculated subperitoneal tumor.

He held the opinion that all fibroid uteri should be removed as soon as discovered, because the woman with a fibroid is liable not only to hemorrhage, which may not be great, but to reflex disturbances of digestion and circulation. Besides, every day it grows, its removal is becoming more dangerous, and the chances of its becoming malignant are greater.

He was opposed to a preliminary curetting, because it was unnecessary, and, second, because when done it was seldom done effectually; having examined in a foreign city a fibroid uterus immediately after removal which had been curetted just before, he had found only about a twentieth part of the uterine mucosa removed.

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He was strongly opposed to vaginal morcellement which is not to be compared with Pryor's method. It is much more dangerous, much more difficult, and keeps the patient a much longer time under the anaesthetic. The operation is carried on in the dark, and the ureters are frequently wounded, while complications such as adhesions of the vermiform appendix, and tears off the intestine which are easily dealt with by the abdomen, and the patient in the Trendelenburg posture is almost impossible to manage when working from the vagina. Moreover, nearly all women with fibroids are nulliparous, and the vagina is consequently narrow; they are nearly all elderly, and the passage is consequently inextensible. No more unsuitable class of patients could therefore be chosen for this most difficult vaginal work. The author strongly advises the closure of the abdomen with through and through silk worm gut left in for three, or, better still, four weeks. If not tied too tightly, and if dressed with boracic acid in abundance, the one dressing or at most two will suffice from the beginning to the end of the case. Besides they can be passed very quickly, thus saving ten minutes in the duration of the anaesthesia.

248 Bishop Street.

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## VALEDICTORY.

*To the graduating Class delivered at the Annual Convention, held in the Synod Hall, Montreal, 26th April,* 1900.

By Andrew Macphail, B.A., M.D.; M.R.C.S., Eng.; L.R.C.P., London.

Professor of Pathology, University of Bishop's College.

Mr. Chancellor, ladies and gentlemen,—But it is to you, graduates, that I direct myself, being chosen by my colleagues to address to you a word of farewell, and if I import into the task something of what I feel, it is because this is an occasion differing essentially from the meetings of the class-room or the examination hall. Our relations are changed. There, it was our place to speak with authority, not with the authority of office, but in virtue of possessing a little more knowledge than you. I say a little more, because in com-

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parison with the whole mass the difference between our attainments is not so great as the incautious might suppose. There was a time when teachers pretended to teach, ex cathedrâ, but that time passed away with the written lectures which did duty from year to year. The scientific heresy of to-day is the common sense of to-morrow, and all we have striven to do is to set the subjects in order before you that you might see them as they are, or at least as we conceive them to be, remembering that the order and material is subject to instant change, that the things which are according to our knowledge are continually passing into uncertainty, that the things which can be shaken are passing away to make room for those which cannot be shaken, the things which are true.

This occasion is too serious for vaunting ourselves upon our own facilities for teaching, or depreciating the facilities which others possess. We are all engaged upon the same work, and any one who casts stones at his neighbor is more fitted for casting stones than for the serious business of teaching. We are a small school, but it is a new doctrine that efficiency goes with numbers, either of teachers or of students. With us it is a labor of love. We teach because we like it, and we only ask to be left alone to practice our harmless amusement in our own way. Yet at home and abroad we see our school, its future full of promise, occupying the same official rank as others, and, best of all, our graduates maintaining their place in learning and in practice. You are now sharers in this burden.

I lament that I do not see before me all of those who were an inspiration to us in the class-room. A teacher is more dependent upon you than you are on him. To the missing ones, I have this to say: We did it through kindness, we thought there was something more you could profitably learn; something more we would gladly teach you.

It is now too late to talk to you specifically of your work or of your leisure. If in the last four years we have failed to impress upon you habits of industry, you will not learn them from anything I can say, but if you have love for your fellow men, you will be industrious in their service. It is of your leisure I would say one word. Do not waste your time

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on that kind of reading which results in acquiring ideas which bind instead of feed you. In the too current medical literature, you get only the froth and scum. It would be better for you and your patients if you were to be reading Montaigne's Essays for example, than all the medical journals published on this continent the last year.

Meeting in this Synod Hall reminds me that for more than a generation the contest has raged between those who stood for science and those who stood for what they called religion; the fools on one side crying, "There is no God," the fools on the other side crying, "There is a God, and we know all about Him." All this has passed away and the small voice is prevailing over the tumult, the voice of wisdom proclaiming that it is all an affair of the heart, a thing for the individual, a matter of character, that after all the principal thing is kindness. And this practice of medicine above all other professions affords you occasions of exercising kindness. Look at those who are kind to the outpatients; they are the real physicians, whose names will be held in remembrance, and, if you see a man jocular or cynical or austere with the outpatients, that is a man who is a brawler and a stirrer up of strife in his own household. The man vain of his attainments; jealous for his own glory and suspicious of his own fellows is more fitted for the street than for the bedside.

Therefore, I adjure you to go quietly; to walk humbly, living your own life, striving to educate yourselves, to raise yourselves out of the class in which we are all prone by nature to lie; not to be concerned about the outward things which lead to luxury, but to kindle a flame within yourselves and you will thereby be a light to the place in which you are, by having light in yourselves, above all, striving to make it prevail by its steady burning and not by blowing it with wind. Then you will not fret yourselves over the man who is sleek of manner and smooth of tongue, over the man who has the latest scientific word in his mouth, the man who alone can heal, and that only because he was called in time; all these are the brood of the Seventh Son; they flourish and have had their reward.

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In addressing you I feel as if I were taking part in some solemn rite, a ceremony by which you are being adopted into our number, by which you are made partakers in the responsibilities and the privileges of a special caste. And this is literally exact. In the beginning, as Spencer proves, the priest and the physician were one; in the highest sense this is still true, as true as the connection between moral fault and disease is intimate.

I would have you remember that the meaning of all this ceremony is that you are now accredited as healers of the sick, and any medical teaching which aspires to make anything else, to make pathologists, physiologists or chemists, is missing the mark. If any of you have an interest in these things apart from their bearing upon the healing of the sick, it is as if you were dealing with any. other business, like heraldry or the counting of coins. There is a proper scientific study of those subjects cognate to medicine, but the glamor that has been cast over them is apt to blind you to your real mission. Of these subjects you must know something though you need not aspire to be handworkers in them. You must come to them continually for direction, else you will lose your way in the dark and waste your effort in empty speculation. I am not forgetful of the value of the work that has been done by men whose amusement and interests lie in discovering truth, but the discovery of truth is a different matter from the healing of the sick. After all these discoveries, we cannot do everything by their means. Read your text book in medicine in a new light, and note how page after page contains the melancholy words, "uninfluenced by treatment," "drugs are of no avail," "runs its course irrespective of medication." Yet drugs are not the only nor even the finest weapons in our armory. The lowest member of our class is the giver of drugs. You cannot cure disease any more than you can cure the autumnal flush on a hillside of Canadian maples. It is as "natural" to die as it is to live, and our scientific medicine consists for the most part in observing the phenomena which ends in death, the process by which the dust which we are returns to the dust from which we came. But there is the supreme thing yet you

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can do; you can be the bearer of light and happiness and calmness, a messenger of peace to those who are in pain. The greatest healer was the greatest teacher. It was through works of mercy He brought the truth home to men, and having regard to what I have called the intimacy between moral fault and disease, what does it matter whether the message be, "Thy sins be forgiven thee," or whether it be, "Arise and walk."

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# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine University of Bishop's College; Physician Western Hospital.

### THE HYDRIATIC TREATMENT OF HYPERCHLORHYDRIA.

Olsen, in *Modern Medicine*, for December, reports a case of nervous hyperchlorhydria, a man aged 26, treated by means of the hot and cold trunk pack in conjunction with other hydriatic measures; the patient making a rapid recovery.

The following is an outline of the treatment:

Fomentations to the stomach and bowels with a hot foot bath, spray and general faradization twice a week; electric light bath two to five minutes, salt glow and spray twice a week; hot and cold trunk pack, and cold friction sponge twice a week; mechanical Swedish movements, including vibration, kneading, friction and percussion half an hour daily; specially prescribed gymnastic exercises half an hour daily. His diet consisted of toasted breads, such as granose, zwieback, wholewheat wafers, rolls, etc., with mild fruits, especially stewed California prunes and steamed figs, also especially prepared nut foods. Of the nut foods, malted nuts and protose gave excellent results in this case. An hour's moderate outdoor exercise was taken daily. At the end of two weeks the patient still complained of some epigastric pains, although not as severe as before. The bowels were now regular.

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At this time the bathroom treatment was changed to the following: Hot and cold trunk pack, salt glow and spray three times a week; hot and cold trunk pack, hot and cold percussion douche to the spine, talcum powder rub, thrice a week. Within a week the gastralgia and flatulence disappeared, and the patient made a rapid recovery. The bowels were regular, and there was a marked gain in strength and weight.

In cases of hyperchlorhydria the writer has found the hot and cold trunk pack an excellent means of decreasing the amount of hydrochloric acid secreted.—*The Charlotte Medical Journal.*

## THE RELATIVE INTENSITY OF THE SECOND SOUND AT THE BASE OF THE HEART.

Creighton, in the *Medical Record* for January 13th, gives the result of a study of 1,000 cases.

The pulmonic sound was the louder in 291 cases, the aortic in 486 cases, and the two were of equal intensity in 223. The cases were from 10 to 29 years old.

She concludes that accentuation of this pulmonic second sound is almost invariably in young children and frequent in youth.

After the fortieth year of life, the reverse is the case, and it is then rare to find a pulmonic second sound as loud as the corresponding aortic sound.

Between the ages of twenty and thirty years there is no marked accentuation of either sound.

In view of the above facts, it is obvious that when one speaks of an accented pulmonic second sound as corroborative of a diagnosis of heart disease, such accentuation must mean an increase in the loudness of the sound over that normally to be expected at the age of the patient in question. A comparison with the aortic second is not sufficient to settle the question.

Further, when we speak of an aortic second sound as accented, we must mean (in case of a patient over forty years) more accented than it formally is. Once more, the simple comparison with the pulmonic second sound will not settle the question. The comparison must be with an ideal standard carried in the mind.

In interpreting the meaning of an accentuation of the pulmonic second in suspected mitral stenosis, one must bear in mind the age of the patient. The presence of a pathological accentuation of the sound can be determined only in re-

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lation to the degree of accentuation which is to be expected at the age of the patient in question.—*The Charlotte Medical Journal.*

## THE FUTURE OF APPENDICITIS CASES.

E. J. Cottier (*Revue Mensuelle des Maladies de l'Enfance*), in examining the ultimate results in 86 appendicitis cases treated by Broca, ranging in age from a few months to fifteen years, divides them into three classes: (1) Patients not operated on; (2) patients operated on during an acute attack; (3) patients operated on in the afebrile period. Cottier's aim is to show by analysis of Broca's statistics that the latter is justified in taking a position against immediate operation in every case, and against searching for an appendix which is at the bottom of a purulent-cavity. Of these (*a*) 19 went out without operation: of the 19, 5 returned after a fresh attack, and were operated on in the afebrile period; 13 had no pain after the operation, and remained well; 1 had slight colicky pains. (*b*) 47 were operated on during the acute attack; 1 for general peritonitis. The appendix was removed from only 3. Of these 47, 28 had no trouble afterwards and remained in perfect health; 4 went out with a fistula, and were subsequently operated on and remained in perfect health. (*c*) 30 operated on during an interval (8 of them had been operated on previously during an acute attack). At the time of writing, all 30 were in perfect health; 3 showed slight separation of the muscular walls, and a slight impulse on coughing. (*d*) 3 died of intestinal obstruction, due to peritoneal bands, at intervals of eight months, one month and seven months after operation; one of these was not operated on in the first place by Broca. Two were suppurative cases, showing how adhesions were the cause of accidents: one of these was an operation in the acute stage for abscess; one was operated on in the afebrile period, but in this the extent of the suppuration necessitated drainage, and a temporary fœcal fistula occurred. All the patients were seen again from six months to five years after they left the hospital.—*Treatment.*

## TREATMENT OF NEURASTHENIA.

The close contact of physician with patient is of extreme importance in the cure of neurasthenia, according to O. Dornbluth (Munch. med. Woch., January 16, 1900). A thorough physical examination will awaken confidence and

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prevent errors of diagnosis, and the patient should be informed of the true character of his disorder. The most important rule is to keep the patient in bed and absolutely at rest from one to six weeks, depending on the severity of the case. Where this is impossible, the recumbent posture should be assumed during all leisure moments. Strict dieting is not necessary; even coffee and tea may be allowed, but alcohol is to be strictly interdicted. Even when nervous dyspepsia is present the regular plan of feeding five times daily at intervals of two and a half to three hours is admissible, but when great irritability of the stomach dominates the clinical picture, the diet should be similar to that for gastric ulcer, or solid and liquid food alternately every one and a half hours may be given. To quiet the nervous system the best results were obtained by applying cloths wrung out in water at 59 deg. F. to the abdomen and covering these with flannel, or by giving a bath at 81-88 deg. F. with the tub but half filled, for four minutes. Massage is not to be resorted to, but general faradization with weak currents is excellent. As for drugs, a depreciated condition of the blood demands iron, preferably in organic form, while, for the severe manifestations of the disease codeine acts almost as specific. In selecting sanatoria, especial care is necessary to choose such which really meet the indications.—*Medical News.*

## THE HOSPITAL TREATMENT OF MELANCHOLIA.

Babcock, in the *International Medical Magazine* for January, discusses the treatment of acute and curable forms of melancholia.

He divides the curable forms into acute, agitated and stuporous.

The first indication is to combat sleeplessness, and this is done by the scientific use of massage, static electricity, cold baths and sponges, and well regulated outdoor exercise, leaving a very limited field for the use of hypnotics.

The second indication is to keep the patient well nourished. Salines and intestinal antiseptics should be administered with the first food given artificially. For forced feeding give three eggs, four ounces of expressed meat juice and one quart of milk twice daily.

Lavage, careful attention to the bowels, constant nursing, alteratives and excito-motors as quinine, strychnine or nuxvomica, iron, arsenic, coca, hypophosphites and bitter tonic are indicated.

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Opium should not be used except cautiously in the agitated form.

Melancholia with stupor should be treated as above with special attention to the eliminative functions. Weir Mitchell's rest cure is applicable in this form. The cold pack for sleeplessness.

The thyroid extract should be tried, remembering that in many cases no mental improvement occurs until the thyroid has been discontinued, when a mental and physical reaction takes place which does not cease until convalescence is well established.—*The Charlotte Medical Journal.*

## INTRA-AURAL APPLICATION OF CHLOROFORM IN TRIGEMINAL NEURALGIA.

The author describes the method of application as follows:

"Taking two small pledgets of cotton wool, which I soaked with chloroform and then wrapped up separately in more cotton wool, I placed them just inside of the external auditory meatus. In about 30 seconds the patient complained of a burning sensation, and as this increased the headache decreased, and in another 30 seconds disappeared for good."

With the aid of his assistants, the author succeeded in curing over 500 cases of trigeminal neuralgia by this method. He gives the detailed histories of 18 cases.

In conclusion, the author states that his own experience of the effects of chlororform teaches him:

1. That it rarely fails to give even temporary relief, and only twice aggravated the pain.

2. That it is only a pallative in neuralgias due to fever or dental caries, and in some cases of inflammatory origin, but it is a curative in very many cases of inflammatory, reflex and inexplicable origin and in cases due to anemia, insomnia, and exposure to the sun or to cold.

3. It removes all manner of uncomfortable sensations from the trigeminal area, and is probably the best remedy for neuralgias in neurotic persons who cannot bear internal medication.

4. As one application usually suffices to cure pain that has lasted from a few hours to a few weeks in over 50 per cent. of head and face aches, it ought, I think, to be the first remedy to be tried in all such cases. (S. C. Bose, *Indian Med. Rec.—The Post-Graduate*).

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## TRACHEAL DIASTOLIC SHOCK IN THE DIAGNOSIS OF AORTIC ANEURISM.

The author points out the value of the tracheal tug in the differential diagnosis of intra-thoracic and aortic aneurism. It must not, he says, be confused with an up-and-down pulsation of the trachea, which normally occurs in many healthy individuals, and accompanies other diseases. In such, however, there is not the distinct diastolic shock (due to the transmission of, or originating at the time of, the closure of the aortic valves), which, traversing the aneurism, is manifested by a distinct sharp impulse following the tracheal tug at the same intervals as that between the apex beat and the closure of the aortic segments. The author details four cases in which the sign was clearly present, and in which necropsy or after-events proved the diagnosis to be correct. The crucial test of the value of the sign, says the author, should be in differentiating aneurism from solid thoracic tumor in cases not involving the chest-wall. We must conclude, however, that if diastolic shock is of value, as it certainly is, in establishing the diagnosis of aneurism in case the tumor is accessible to palpation, it should be of equal value in case no palpable tumor exist if transmitted through the vascular tumor to the trachea. – (Dr. J. N. Hall, *Am. Jour. Med. Sc.* — *The Post Graduate*).

## DILATATION OF THE STOMACH.

The author's conclusions are as follows:

1. The symptoms upon which most reliance can be placed in determining the presence of gastric motor insufficiency are: *a.* The presence of fluid and food in the stomach fasting over night; *b.* the ready entrance of fluid through the tube and difficulty in the return flow; *c.* the absence of visible gastric peristalsis; *d.* evidences of fermentation and intoxication by the products thereof; *e.* thirst, and *f.* scanty and concentrated urine.

2. In determining the position and size of the stomach, by far the most certain method has been inflation by air through the stomach-tube; ascultatory percussion, Dehio's method, and determining the capacity of the stomach by the amount of water required to produce a sense of fulness, while signs of value may lead to error.

3. It may be inferred from the somewhat small number of cases reported by the authors that the condition is not un common in students. An analysis of the etiological factors is as follows: *a.* Myasthenia caused by chronic gastritis from abuse of alcohol and tobacco, four cases; *b.* myasthenia from

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deficient innervation, two cases; *e.* myasthenia, probably of congenital origin, one case; *d.* myasthenia occurring in the course of acute disease, one case.—Drs. Musser & Steele, *Am. Jour. Med. Sc.*—*The Post Graduate.*

## DIET IN ACNE.

The well-to do (Dr. Jackson, in "Manual of Diseases") are prone to eat too much, and it is remarkable how rapidly their acne will improve by reducing their diet to the simplest elements. In many of them a milk diet—provided milk agrees with them—will accomplish a marked benefit. On the other hand, says the Columbus *Medical Journal*, many young girls almost starve themselves under the mistaken idea that a low diet will give them a fine complexion. Nothing could well be less true than this. Especially is there a prejudice against butter. The old explanation that skin eruptions were mainly due to the use of too much butter still remains absolutely true for most non-medical people, and even for some medical men. That butter should be used freely, and that cod-liver oil and iron are the only drugs required in many cases, as Dr. Jackson insists, would to these good old conservatives seem rank heresy. It is evident that more definite ideas as to the diathesis that underlies the etiology of acne have been acquired, and that the dietetic management of it, rather than any empiric use of vaunted specifics, constitutes the most modern therapeusis of this extremely frequent and bothersome condition.

## MEDICINAL PROPERTIES OF ONIONS.

Onions are a kind of all-round good medicine (*Winnipeg Lancet*). A whole onion eaten at bedtime will, by the next morning, break the severest cold. Onions make a good plaster to remove inflammation and hoarseness. If an onion is mashed so as to secure all the juice in it, it will make a most remarkable smelling substance that will quiet the most nervous person. The strength of it inhaled for a few moments will dull the sense of smell and weaken the nerves, until sleep is produced from sheer exhaustion. It all comes from one property possessed by the onion, and that is a form of opium.

## TREATMENT OF NIGHT SWEATS OF PHTHISIS BY FORMALDEHYDE.

The good results of treatment by this drug seen in cases of hyperidrosis and bromidrosis caused Hirschfeld of Berlin

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to try its action for phthisical sweats. He now recommends it highly. Because of its power of penetrating the skin, he uses an alcoholic solution, as follows:

℞ Formaldehyde, 40 per cent.
Spiritus abs.....aa ʒ ij.
M.
Sig. External use. Apply on swab.

Only one part of the body is treated at one sitting; the shoulders and arms, for instance, on the first day; the lower extremities on the day following, and the trunk on the third. From 1 to 2½ drachms of the solution is used each time. By following this method, toxic absorption and excessive irritation of the ocular and respiratory mucous membrane are alike avoided. If, nevertheless, a fit of coughing should be provoked, the application should be made very rapidly and the part covered at once. Cotton wet with spirits of turpentine can be held in front of the nose and mouth of a sensitive patient. The treatment is not painful only a momentary burning sensation being produced. Newly-formed epidermis, excoriations and mucous surfaces should, of course, be avoided. The effect of the application lasts from five days to a month—as a rule, from one to two weeks. The sweats cease meanwhile, and as no injury is caused by the treatment, it can be resumed whenever necessary.—*Med News.*

## SPRING COUGHS.

Dr. George Brown, Eye, Ear, Nose and Throat Specialist, of Atlanta, Ga., in a timely article in *Moody's Magazine of Medicine* said —"Nothing is more annoying to a patient than a perpetual tickling cough. Whether the immediate cause be marked or mild, if allowed to continue the results are almost sure to be more or less serious. The paroxysms initiate untoward reflex impressions, augment the local disturbances; and by interfering with the patient's rest depress the vis vitae, making the sufferer readily susceptible to the inroads of other attacks. As practitioners are aware, tickling coughs are particularly numerous and stubborn during the spring and fall. It is well, therefore, at such times to prescribe that which will be sure to relieve without unpleasant after-effects. In nine cases out of ten Antikamnia and Codeine Tablets will be found almost a specific. The well-known analgesic properties of Antikamnia act excellently and synergetically with the physiological effects of Codeine, which has a marked salutary selective influence on the pneumogastric nerve, making this combination one of the most valuable in medicine."

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## RHEUMATIC GOUT.

In addition to dietetic, hygienic and hydrotherapeutic measures, Dr. B. C. Loveland (*New York Medical Journal*, March 3), has found sodium salicylate and potassium iodide most useful. Five grains each of sodium salicylate and sodium benzoate, given in a glass of hot water three times a day, has a very good effect and is well tolerated. Potassium iodide is of great service in some cases; in others sodium bicarbonate will do as well as anything if given in repeated doses well diluted. When the alkali most suitable for the individual patient is found, it should be continued for three months steadily, then three weeks out of four for another three or six months.

## TREATMENT OF WHOOPING BY PHENOCOLL.

M. Uargus, of Barcelona, first tried phenocoll in 1895, and derived from it very good results. I have used it, too, in seven children who were attacked with whooping cough during measles. In all there was marked and rapid improvement. The remedy diminished the frequency of the attacks and their intensity; the nocturnal attacks especially were less frequent, and the total duration of the disease notably lessened. The dose administered was from one to two grammes daily. M. Fabistocherski has had like success in forty cases at the Hospital "St. Olga." Without being a specific remedy, phenocoll offers real advantages in whooping cough, and should always be resorted to when other remedies, particularly morphine, are contraindicated, especially in some children, in whom the disease is often dangerous. There are no inconveniences attending its use.—*Med. Rev. of Reviews.*

## NITRIC ACID.

As an internal medicament nitric acid has its own peculiar place, and we use it quite often. The marked redness of and slick mucous membranes, indicating the use of an acid, are not only present, but there is besides a very marked purple or violet tinge. The late Prof. Scudder laid great stress upon the color when writing of nitric acid and of baptisia. It may be used in any disease when these indications prevail. It is said that a too long use of nitric acid causes hypersecretion of saliva.

Nitric acid has frequently a very pleasant effect in malignant typhoid fever, diphtheria, scarlet fever, etc. It brings about changes that directly or indirectly favorably influences

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the temperature. It is an excellent remedy in many cases of chronic ague, and in gastro-intestinal dyspepsia. One of the most prominent writers upon materia medica and therapeutics recommends the administration of nitric acid in the "green stool" diarrhea and in chronic diarrhea of children. We have had no experience with it in these troubles. We believe it should not be given simply because the stools are green.

Nitric acid, according to our experience, is very often the indicated remedy in whooping cough, and is very efficient. We have thought that in this disease we could more often see in nitric acid Prof. Scudder's "epidemic remedy," than in any other. The dose of nitric acid is from ten to fifteen drops in four ounces of water, a teaspoonful of the mixture every one to four hours.—*Cincinnati Med. Jour.*

## TO REMOVE THE ODOR OF IODOFORM.

Dr. Edwin Ricketts states, Cincinnati Lancet-Clinic, a teaspoonful of vinegar rubbed on the hands after thorough cleansing with soap and water, "does away promptly with the very disagreeable odor" of iodoform.—*Penn. Med. Jour.*

## BELLADONNA IN THE BRONCHO-PNEUMONIA OF CHILDREN.

Hodghead (*Pediatrics*, September 1, 1899) reports a case in a child eighteen months old, where, on the treatment ordinarily used in pneumonia, the child gradually failed, when he determined to use the following: The child was wrapped in soft, loose clothing; water was given instead of milk; the atmosphere of the room was made moist and kept at an even temperature. One-twelfth of a grain of calomel was given every hour until the bowels were moved, and two drops of tincture of belladonna given every hour. In twelve hours a marked improvement was evident, and in twenty-four hours, all the symptoms were so much improved that the belladonna was gradually decreased, and the child made a rapid recovery. Based upon this case, a series of experiments was begun, with the result that in twenty-five cases of his own, and five in practice of other physicians, there were twenty-eight recoveries. He concludes (1) that calomel should be used in small doses until a cathartic effect is secured; that the belladonna in small doses is mildly narcotic, and brings about a condition less uncomfortable to the

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child; that it is a heart-tonic; that it is a respiratory stimulant, and that it produces dilatation of the superficial capillaries, and relieves the congested lungs. The most important influence, however, is that it diminishes the secretion in the bronchial tubes and the pulmonary tissues. To be effective it has to be used every hour or two, until the desired effect is obtained. The drug has not been found effective in the beginning of the disease, but becomes especially applicable when the bronchial secretion is abundant.

## HAY FEVER.

Douglass (*New York Medical Journal*, September 2, 1898), after speaking of the local remedies which he always uses, says, "The most important remedy to use internally is dried suprarenal gland." In his experience, it is almost a specific for the symptoms of hay fever, and a remedy to safely and surely restore the over-distended condition of the nasal erectile tissue. It may be used either as a spray to the mucous membrane of the nose or internally. The tablets are given every two hours day and night until some prostration is produced. They are then discontinued.

## ANTIPYRIN IN DYSENTERY.

The *Maryland Medical Journal*, September 2, 1899, quotes from the *Therapeutic Gazette* the following: Seventy-five grains of antipyrin are dissolved in eight ounces of water and used as a rectal injection, given three times a day, and retained fifteen minutes. It is claimed that the relief from pain and tenesmus is immediate and the number of stools is decreased, and that convalescence is speedily established.

## WATER TREATMENT OF GASTRO-INTESTINAL DISTURBANCES.

Marfan advocates an exclusive diet of water for infants with diarrhœa or other gastro-intestinal disturbances, the amount corresponding to the usual amount of milk ingested. A number of our Southern and European confrères have found this treatment extremely effective, and a communication in *El Progresso Medico* for August describes cases of diarrhœa during the war in Cuba cured in three to five days with nothing but water taken freely, boiled and cooled to the temperature of the room.—*Journal of the American Medical Association.*

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## TREATMENT OF RENAL CONCRETIONS OF URIC ACID WITH GLYCERIN.

Dr. Hermann (*Med. Chron.*, Jan. 1900; Ref. *Brit. Med. Jour.*, No. 2040, Epit. p. 28) has obtained favorable results in nephrolithiasis by the administration of glycerin by the mouth. He gave it in the first instance on theoretical grounds, based on the facts that glycerin is a solvent of uric acid, and when given *per orem* it is excreted in large part with the urine. The good effects he has observed he does not now attribute to any solvent action of the glycerin on the uric acid, but to physical changes produced in the urine. When given in the large doses he employs, it causes the urine to become somewhat oily in consistence, and to its lubricating action he believes the good results are to be ascribed. Rosenfeld, who has also praised the method, believes it to give relief by raising the specific gravity of the urine and thereby producing a change in the position of the calculi in the pelvis of the kidney. It is given in quantities of from one to four ounces, dissolved in an equal quantity of water, and taken as one dose, between two meals and repeated two or three times in a period of several days. He has used it in 115 cases of nephrolithiasis, and in 60 per cent. of these it proved efficacious either by removing concretions or by relieving the pain associated with the disease. Ortner and Kugler have confirmed the stone expelling power of glycerin, while Casper and Rosenfeld speak of its anodyne effect as simply astounding. Given in the doses named, the only unpleasant effects observed were headache in twelve nervous patients, and diarrhœa in three cases where the digestive organs were not healthy. In all the fifteen cases these effects ceased in the course of a few hours. In such patients, and indeed in others, it is recommended that the initial dose should be smaller than the minimum dose named, and that it should be gradually increased. The presence of albuminuria does not contraindicate the employment of glycerin; the amount of albumin was never increased, and in one case, after three doses of the agent, the previous albuminuria completely disappeared. In six cases of the 115, hematuria occurred, and this the author ascribes to the concretions changing their position either spontaneously or owing to the glycerin. —*Post Graduate*, April, 1900.

## TANNOPINE FOR INFANTILE DIARRHŒA.

Dr. D. E. Smith, of Minneapolis (*Northwestern Lancet* November 13, 1899), states that in cases of diarrhœa charac-

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terized by copious serous discharges it is necessary to resort to some astringent which would be antiseptic and not absorbent to any extent. Tannic acid was the drug par excellence, but it has been dismissed by the profession on account of its unpalatability, its bulk, its taste, its rapid absorption in the upper intestinal tract, and its rapid decomposition. Recently a chemical combination of 87 per cent. tannic acid and hexamethylen-tetramine has been introduced under the name of *tannopine*, which the author considers an ideal remedy in this class of cases. It is given in small doses from three to ten grains every three hours. Il does not break up until it comes in contact with the alkaline medium of the lower intestine, when the tannic acid is freed and the hexamethylen-tetramine liberates the most desirable of antiseptics, *formalin*. Children take tannopine readily as it is tasteless and small in bulk. It may be given either on the tongue or in any kind of nourishment. The formalin destroys the germs already attenuated by previous treatment. As soon as the serous discharge is stopped there is an immediate improvement in the patient's condition.

## EXPERIMENTAL INVESTIGATION OF THE FUNCTIONS OF THE HUMAN SALIVA.

The investigations of Shule concerning the diastatic energy of the mixed saliva resulted as follows: The secretion increased from morning until noon, while the maximum would be reached between 11 a.m. and 3 p. m. after which time it would gradually decrease.

Further experiments confirm the reports of Biernacki, according to which the secretion of pepsin and HCI, progress much better in the stomach when the food has passed the mouth and has been thoroughly incorporated with saliva than if it had been introduced through the stomach tube. This shows that the secretion of HCI, is reflexly excited by suitable food in the buccal cavity and by the act of mastication.

(This would be a good criterion for taking the principal meal at this time of day.) Schüle, Archiv, fur Verd. Krank. —*St. Paul Med. Jour.*

## DILATATION OF THE STOMACH.

This paper presents the histories of eight cases of atonic dilatations of the stomach; occurring in patients of about the same age (19-28) the same sex (male) pursuing the same vocations (students) and, in a measure possessed of similar habits—(sedentary).

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The author considers it sufficient to place dia tation under two heads as suggested by Pepper and Stengel, viz: Dilatation from atonic and Dilatation from pyloric obstruction.

In only one of reported cases was there an associated gastroptosis.

*Etiology*:—Some of the etiological factors present in the cases were the following:

Sedentary occupation and inherited tendency.

Poor fare, excessive application and sedentary habits.

Privation incident to a course of study with insufficient means. Congenital weakness of tissues and over use of alcohol and tobacco. Typhoid fever was believed to be a factor in one case.

*Dignosis*:—The following points are mentioned as of especial significance and value:

Presence of fluid in the fasting stomach—(Early morning lavage). Characteristic freedom of inflow through stomach tube of the water used in lavage, contrasting strongly with difficulty experienced in emptying the stomach. Inspection was found to be of little use in this class of cases. No peristalic waves were seen. The urine was almost always scant and of high color and specific gravity.

*General symptoms.*—Insomnia, lack of mental concentration and initiation, muscular weakness, pain and twitching, eructation of gas and bitter fluid, appetite usually good, thirst moderate.

*Differential diagnosis*:—From cicatricial stenosis following ulcer—it is differentiated by absence of a history of haematemesis and other symptoms of ulcer. From cancer by the age and absence of tumor and the presence of hydrochloric acid. Pyloric obstruction in general is excluded by the lack of visible peristalsis and the slow return of fluid introduced by tube. From duodenal stenosis by the absence of bile from the stomach contents. J. H. Musser and J. D. Sceele, Am. Jour. of Med. Science.—*St. Paul Med. Jour.*

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# SURGERY.

IN CHARGE OF

ROLLO CAMPBELL, M.D.,

Lecturer on Surgery, University of Bishop's College ; Assistant-Surgeon, Western Hospital ;

AND

GEORGE FISK, M.D.

Instructor in Surgery, University of Bishop's College ; Assistant-Surgeon, Western Hospital.

## A NEW INVAGINATION METHOD OF INTESTINAL ANASTOMOSIS.

The author describes a new method of anastomosis which he has employed with success in a number of cases, and has proved by experimentation on animals to be technically efficient in all cases. A strip of mucous lining is removed from the inner surface of the distal end of the intestine, so that it permits the proximal end to be invaginated into it. When this has been accomplished it is held in place by fixation sutures, while a continuous suture unites the cut end of the gut, with its raw muscular layer, to the serous surface of the proximal or invaginated portion. The process of invagination protects the stitches and the line of union in a degree from contamination by the intestinal contents while strengthening it against pressure from within. The denuding of the muscular coat where it is brought in contact with the serous surface of the proximal portion, in the line of union hastens the reparative process, and frees the wound from the contamination of the intestinal contents.

The histological examination made on the experimental cases shows that firm adhesion is present in twenty-four hours, and that there is no contraction of the lumen of the gut. The method is free from the objections made where foreign bodies are employed, while the suture line is protected from infection from within the bowel.—Dr. Morisani. *Centbl. f. Chir.* (*The Post-Graduate*).

## SUTURE OF FRACTURED PATELLA BY AN IMPROVED METHOD.

The author employs silver wire as suture, and a single drilling of each fragment only. The suture is a D-shaped wire, No. 16 gauge, made of the softest silver, which, being flat on one surface and very broad, is free from the tendency to cut through the drill hole, and strong enough to admit of

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only a single suture being inserted. It was found that this wire was sufficiently strong for one suture to hold together, under considerable strain, the sawn ends of a patella, and also that, on account of its shape and strength, a single loop of each end, interlocked, was quite sufficient to secure the suture, and the ends could be readily flattened down without forming any appreciable foreign body which could irritate the surrounding tissues.

The author cites a case of transverse fracture of the patella in the lower third, with an inch separation, in a male aged 24. Four days after the accident the joint was opened by a large U-shaped flap, having its convexity downwards, just below the ligamentum patellæ and extending laterally well away from the margins of the fractured bone. On opening the joint, a large number of firm and partly decolorized clots were freed and washed out with sterilized water. After drilling the two fragments, the D-wire was passed, accurate approximation of the fragments secured, the wire looped, and the aponeurosis and periosteum closely sutured with fine silk over the overlying wire. In this way the fractured surfaces were completely protected. The author regards this as one of the most important steps in the operation. The skin flap was then closed with salmon-gut sutures, and when put in position no trace of the wire loop could be detected with the fingers. Aseptic dressings and light posterior splint were applied, and the limb kept elevated. On the eighth day the sutures were removed, the skin incision being soundly healed, On the 14th day the splint was removed to admit passive motion. A skiagraph taken three weeks after the operation showed such accurate approximation that the line of fracture could only be faintly recognized. Four weeks after the operation the patient could walk without aid of a stick, and eight weeks after operation he was able to walk two miles on a level, the only remaining evidence of injury being a slight feeling of weakness on going up stairs.

In conclusion, the author offers the following:

In young and healthy subjects the ideal operation is primary suture; and with care and strictly asceptic precautions it offers no more grave risks than many of the forms of so-called subcutaneous suture, while in relative accuracy and efficiency no reasonable comparison can be established. Among the important points connected with the operation the author specially emphasizes the following;

1. The advisability of delaying operation for a few days after the injury until the subsidence of the more acute symptoms in the joints.

2. The thorough clearing out of the joint; all the recesses

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of the synovial membrane being completely freed from clots, and the broken surfaces of the bone thoroughly cleaned. This can only be secured by the open operation.

3. The use of an easily sterilizable suture, strong enough to secure apposition by a single drilling, and so shaped as to render splitting of the bone an impossibility, and to prevent in fastening it the formation of a large and irritating loop.

4. The elevation, and not the resection, of the fibrous curtain, and its subsequent accurate suturing over the imbedded wire, forming an additional barrier underneath the skin flap against infection or irritation.

5. The early commencement of passive movement, which is thus rendered feasible, and undoubtedly shortens the period of disability following the fracture—a point of paramount importance to the class of persons most subject to the injury.—Dr. R. G. Patterson —*Brit. Med. Jour.*—*The Post Graduate.*

## TREATMENT OF ANEURISM BY SUBCUTANEOUS GELATIN INJECTIONS.

The author draws the following conclusions from his experience with the gelatin treatment in nine cases, at the Johns-Hopkins Hospital:

1. In not a single instance has the aneurism been cured, although in one case the abdominal aneurism has diminished considerably in size, and the case is still under treatment.

2. In seven of the nine cases there was an appreciable diminution in the subjective symptoms referable to the pressure of the aneurism.

3. It seems quite certain that the subcutaneous injection of gelatin solution does materially increase the coagulability of the blood.

4. Contrary to the statement of Lancereaux, we have found that the gelatin injections are frequently very painful to the patient, the pain lasting and being most intense often as late as six hours after the injection.

5. Athough Lancereaux states, that with strict antiseptic precautions there should be no elevation of temperature, we have found the contrary. In several instances, the injections were followed, two to four hours later, by a distinct chill, with an elevation of temperature reaching at times as high as 103° F. In no case did we have any local suppuration, and in only one case was there even any local reaction.

6. Notwithstanding the fact that we have not yet a case which can be reported as cured, we are convinced that there

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is some merit in the treatment, and that it deserves a further trial.—Dr. T. B. Futcher—*Jour. Am. Med. Assoc.—Post-*

## FORMALIN IN SURGICAL TUBERCULOSIS.

Hahn (*Centralblatt fur Chirurgie*, No. 24, 1899) states that he has obtained excellent results from a mixture of formalin and glycerin, 1 to 5 per cent., in the treatment of surgical tuberculosis. As an injection into abscesses connected with diseased joints, the author believes that this mixture is superior to an emulsion of iodoform.—*University Medical Magazine.*

## DEAFNESS IN CHILDREN.

The following is an original abstract of a paper read by Edward F. Parker, M. D., Charleston, S. C., at the annual meeting at the Tri-State Medical Association of the Carolinas and Virginia, held February 20, 21, 22, 1900, in Charleston, S. C.:

Deafness in young children is so often allowed to go unnoticed because the child is uncomplaining or the parents careless, and is so often mistaken for dullness and inattention that the disability is apt to become fixed and beyond repair before expert skill is solicited.

The most common of the numerous causes of deafness in children is adenoid hypertrophy in the naso pharynx. Recurrent earache and deafness are symptoms which imperatively demand a thorough exploration of that cavity. Faulty ventilation and drainage will invariably produce catarrhal inflammation of the middle ear. The importance of such early examination and treatment cannot be over estimated.

The treatment consists in the administration of appropriate constitutional remedies and in the surgical removal of the exciting cause.

Incurable deafness in adults can often be referred to adenoid hypertrophy in childhood. Particular attention is called to recurrent earache and slight deafness as danger signals never to be disregarded when noticed either by parents or practitioner.

## A REMARKABLE CASE.

By Dr. C. B. JOHNSTON, Monroe, Louisiana

During the Civil War, at the siege of Vicksburg, on the 10th of June, 1863, Capt. Alex. Myatt, of the Confederate forces, received what was supposed to be a fatal wound,

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having been shot in the right eye; the missile afterwards proved to be a Springfield rifle-ball of about 55 caliber. Death did not ensue, but for more than a third of a century the leaden missile was a continued source of torture to its victim. The wounded soldier remained in the hospital until the fall of Vicksburg, the fourth of July. General Grant, who was in command of the Federal forces, visited the Confederate hospital after the surrender, and had his attention called to the nature of the wound, and became so interested in the case that he ordered his staff surgeon to visit the patient and examine the wound. After careful examination, this eminent surgeon agreed fully with the diagnosis made by the Confederate surgeons: that the bullet, after penetrating the eye, had taken a backward course, lodging in the back part of the head, its location making its removal impossible, except at the risk of the patient's life. On the 17th of July the patient was paroled and sent home, a physical and, alas, a financial wreck. Notwithstanding his condition, however, he has accumulated a competency for his declining years and made ample provision for his family.

During these thirty-five years he suffered more or less constantly from the pressure of the bullet, and from time to time visited the most eminent surgeons in hope of obtaining relief, among others the noted Dr. Stone, of New Orleans, but always to no avail.

His sufferings were finally brought to an end, by the services of a dentist, and in a most remarkable manner.

In the fall of 1898, Capt. Myatt called on Dr. Johnston, for the removal of a broken tooth. To the surprise of the operator, a foreign substance, evidently lead, was found to be occupying the depths of the socket, after the removal of the tooth. This seemed so incredible that, at the request of the patient, his family physician was called in to make an examination. A brother dental surgeon, Dr. J. F. Johnston, was called in. After careful examination, the foreign substance was pronounced to be the bullet which had entered the eye of the patient thirty-five years previous.

The operation of removal was tedious and difficult, as it was necessary, with saws and drills, to divide the bullet into sections, and several days were consumed in the operation, as the patient objected to the use of any anesthetic. It was successfully accomplished, however, and the old veteran enjoys life once more, and has gained twenty pounds in weight since the operation.

After removing the several pieces into which the bullet had been divided, the gaping wound was well washed out with peroxide of hydrogen, and then packed with dry cotton

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thoroughly impregnated with iodoform, the dressing being changed about once a week. Some little necrosed bone was thrown off and there is still a little more, but as the patient will not permit the use of any anesthetic, Dr. Johnston proposes simply to assist the powers of nature in completing healing. One small piece of necrosed bone came away through the nostril. The patient is doing well, and has better health and enjoys life more than at any time since receiving the wound in 1863.—*Ohio Den. Jour.*

## A NEW LOCAL ANESTHETIC SOLUTION.

Frank G. Lydston has used as a substitute for cocaine in urethrotomy a fresh 10 per cent. solution of antipyrin in a 1 per cent. carbolic acid solution. The advantages of this combination over cocaine are safety, freedom from constitutional effects, and the inhibition of hemorrhage. The solution should be allowed to remain in the urethra ten minutes, as a rule, before beginning to cut.—*Med Record.*

## SILVER CATGUT AND HOW TO TIE IT.

E. Boeckman, St. Paul, Minn. Catgut, in order to give ideal results, must be selected with reference to tensile strength, cleanliness and sterility. It must be rendered aseptic and then antiseptic, yet non-poisonous and non-irritating. It should be able to withstand dry sterilization. It must be absorbable, but, at the same time, its life in the tissues should be such as to enable a ligature to hold from one to several weeks. Although he has not as yet attained the ideal in the preparation of catgut, the author seems to have approached it in his so-called silver catgut. This is prepared through soaking well-selected, clean, formalized catgut in a 1 to 5 per cent. nitrate of silver solution. The gut is then exposed to the light, thus reducing the silver salt to black metallic silver. It is then cut up in desirable lengths and wrapped in paraffin paper. It can then be subjected to dry heat for further sterilization before using. Silver catgut prepared carefully seems to meet with most of the requirements demanded of an ideal catgut.

## EARLY AND METHODICAL MOBILIZATION IN THE TREATMENT OF INJURIES AND DISEASES OF THE JOINTS.

M. J. Lucas-Championniere, of Paris, in a most interesting address, says that all the old authors and nearly all the

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more recent writers advised rest for cases of every sort. For the joints, which are a part of the motive apparatus, a certain amount of motion is essential to nutrition and conservation of function. In inflammatory joint affections immobilization has no specific effect; it simply allows of more decided action being taken to combat the disease. In contusions it is pain alone which indicates rest treatment; but this must be as short as possible. Sprains are to be treated with massage and early passive motion. In fractures into a joint immediate mobilization is the only proper measure. In dislocations the author has never remarked the well known tendency to recurrence; this he ascribes to immediate massage and passive motion. Open wounds extending into joint cavities must have antiseptic treatment, but not necessarily immobilization; a stiff joint will result unless passive movement be made here. After surgical invasion of a joint cavity the same rule holds good. When not contraindicated by the presence of pain, the author has seen no ill effect of motion in a joint from which pus has been evacuated; in fact, function can be retained by this method alone. After resection, the best play of muscles and the greatest range of movements can be obtained by passive motion instituted as soon as possible after operation. The same applies to arthrectomy. A good result has also followed movement in the tuberculous tumor albus.

## AN EASY METHOD OF REDUCING DISLOCATIONS OF SHOULDER AND HIP.

L. A. Stimson, New York, describes a method of reducing anterior dislocations of the shoulder, which has not failed in ten successive recent cases, and has never required more than six minutes to effect reduction. The principle is that of moderate traction upon the arm in abduction, and the procedure is as follows: A round hole about six inches in diameter is made in the middle of the canvas of a cot, about eighteen inches from one end. The patient is placed upon the cot, with the injured arm hanging down through the hole. The cot is raised upon blocks so that it is at a sufficient height from the floor, and a ten-pound sand-bag is fastened to the wrist of the dependent arm. After a wait of a few minutes reduction is found to have taken place. The procedure is not painful, and is an effectual, easy, expeditious and apparently safe method. Instead of a cot two tables might be used, placed end to end, the head resting on one, the body on the other, with the arm hanging down between them. In dorsal dislocations of the hip the method

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is applied as follows: The patient is placed prone upon a table in such a way that his thighs extend beyond its end. The uninjured thigh is held horizontal by an assistant, to prevent tilting of the pelvis, and the injured one is allowed to hang vertically, while the surgeon, grasping the ankle, holds the leg horizontal (right-angle flexion at the knee), and gently moves it from side to side. If relaxation of the muscles is slow to appear, a sand-bag of five or ten pound weight is placed on the leg close behind the knee, or pressure is made there with the hand. This has succeeded in four-fifths of the cases, and often without the aid of anesthesia. In two cases in which it failed reduction was accomplished by traction in a line midway between right-angle flexion and full extension.—*New York Med. Record; Med. Review.*

## SPINAL FRACTURE PARAPLEGIA.

Robert Abbe, New York, in order to show the relations between the damage in broken-neck cases and the group of symptoms following, cites three cases in which the injury was due to diving into shallow water; a fourth case is reported, the patient having been shot by a Mauser bullet over the second left sacral vertebra, with immediate paralysis below the hips. He summarizes his observations as follows: The immediate signs and symptoms of fracture paraplegia give fairly accurate data for prognosis. If loss of sensation and motion below the injured part is complete and instantaneous, and the patella reflex is lost, the outlook for recovery is almost hopeless. Yet knee-jerk, sensation or motion may be absent, and recovery take place. Partial loss of sensation or motion gives hope that a large degree of recovery may be looked for, the cause in such cases being hemorrhage within the central canal or in the cord substance, or in the meninges. Distribution and absorption of blood-clot take place usually within ten days or a fortnight, and returning sensation follows. Return of motion in complete paraplegia cases does not always go on to perfect restoration. Wrist-drop of one hand, or dragging of one foot, may still remain two or three years after. In cervical fracture paraplegia the fifth vertebral body is most often injured; hence the phrenic nerve derived from the third and fourth branches of the cervical plexus gives the only supply to a respiratory muscle—the diaphragm. The labored respiration by diaphragm only usually results in pulmonary edema and hypostatic pneumonia a few days after the accident. This may be overcome by nitroglycerin internally and

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frequent change of posture. Intestinal fermentation with temperature disturbance easily occurs in high paraplegias, and is speedily relieved by calomel. Regeneration of a pulpified cord is impossible. Restored function is probably always due to absorption of blood, or of the secondary inflammatory deposits, which prolong the pressure symptoms. The persistence of bone pressure at the site of the injury justifies operation as much as in depressed fracture of the skull, because through pressure an injured cord must be further degenerated. Laminectomy should be done as promptly as possible. If the subject be favorable it may be done by expert use of cocain. It will be less painful if done before local meningitis sets in. An X-ray view of the fracture can readily be taken by from ten to fifteen minutes' exposure, and greatly aid the surgeon.—*New York Medical Record; Medical Record.*

## CHLORETONE AS AN ANTISEPTIC AND LOCAL ANESTHETIC.

T. D. Dewar reports two cases of severe lacerated wounds, three of amputation of a finger and one of urethral stricture, in which chloretone was employed for irrigation, as a dressing, and for injection prior to introducing a sound. The results indicate that this new drug possesses decided local anesthetic and apparently also antiseptic properties.—*Therapeutic Gazette; Medical Record.*

## BURNS AND SCALDS.

*Treatment.*—According to E. T. Milligan, burns, when under treatment, should be exposed as little as possible by changing dressings. Morphine should be used hypodermically for pain, and tincture of musk by the mouth as a cardiac stimulant. The latter seems to control shock, due to injury. In burns of the first degree an ointment containing a sedative or carron-oil can be applied with advantage. In burns of the second or third degree picric acid in solution (5 to 1,000) is an excellent application, but a dry dressing is personally favored. A powder containing 2½ drachms of pulverized camphor and 1 ounce each of prepared chalk and magnesium sulphate is one of the best. When powders are used the injured parts should be covered with oiled silk to keep the dressing from becoming entangled in the injured parts. When prostration is great, a saline infusion is of marked value.

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Ellice M. Alger has found that the combination of picric and citric acids, which Esbach long ago devised for the detection of albumin, is more effective than the picric acid alone, in burns of the second degree.

Esbach's solution consists of 10 parts of picric acid, 20 of citric acid and 1,000 of water. Without any elaborate attempts at antisepsis the bullæ and vesicles should be opened with a clean blade and the fluid applied freely, care being taken that the solution reaches the interior of each one. The combination after the first smart has passed removes the pain very quickly. After the excess of fluid has drained off the part may be covered with rubber tissue or soft gauze, and left undisturbed for several days. After two or three days the fluid should be reapplied to such areas as are moist, and the part carefully recovered.

R. H. Gay has obtained good results from using the following in burns and scalds: 1 one pound of mutton-tallow, 1 drachm of English resin, and 1 drachm of bees-wax should be put into a vessel, perfectly free from grease or other substance, over a slow fire. After the ingredients are melted and thoroughly mixed, they are to be removed from the fire and ½ pint of linseed-oil (linum usitatissimum) is to be added, stirring until cool to prevent separation. A few minims may be dropped on a smooth surface to cool, to see whether it is of the right consistency or not. If too soft, tallow should be added; if too hard, oil. It is now ready to pour off into boxes for use. The directions for using are to spread it on old linen, or cotton cloth, to a sufficient thickness, large enough to cover the burn or scald, and to renew daily. This preparation is cooling, detergent and healing, and if instantly applied to burns and scalds will almost immediately stop the pain and prevent blistering.

In the treatment of scalds and burns Edward Roelig finds aristol of great service. After a thorough disinfection and cleansing of the burned area, and the opening of the vesicles, a dressing of aristol salve smeared upon sterilized gauze in a layer of about the thickness of a knife-blade is applied, and this dressing changed daily. The dressing is covered with cotton and held in place with gauze bandages. Granulation and cicatrization occur promptly. In personal cases, at first an aristol salve, consisting of 1¼ drachms; ol. olivar., 2½ drachms; lanolin, 10 drachms, was applied, and, when the wound surface had become smaller and granulations had formed, aristol powder was dusted on, and covered with gauze and cotton.

Vehmeyer has used with good results an ointment containing fluorin, and sold under the name of "Epidermin," in

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the treatment of severe burns and scalds. It should be renewed twice a day. Relief of pain, prevention of profuse suppuration and rapid growth of any islets of undestroyed epidermis are its great advantages.

Naftalan has been found by Richard Bloch to so fully meet the therapeutic indications demanded in burns, whether caused by hot fluids, steam or heated solids, etc., as to be almost a specific.

The use of saline transfusion for burns and shock is recommended in an editorial, which states that, even if the toxæmic condition is not directly improved by the saline injections into the subcutaneous tissues of veins, there is still another one in which this method of treatment may be of great good, in that surgical shock is nearly always present as a result of severe burns and scalds. In shock a condition of profound relaxation of the blood-vessels exists, so that arterial pressure is very low and the vital centres are not properly supplied with blood.

While intravenous injection does not necessarily raise blood-pressure, this method of treatment is capable of readjusting the circulation to such an extent that the evil manifestations of vasomotor paralysis are set aside. It seems, therefore, that, in treating cases of severe burns or scalds, this method of procedure should not be ignored, but should be actively employed.

Patel notes the case of a child, aged 2½ years, who had a burn of the second degree, involving, more or less, both arms and legs, face and trunk. The general condition was bad, the pulse imperceptible and the child unconscious. Caffeine, alcohol, bouillon and milk were given. On the third day 250 cubic centimetres of saline solution were injected, and on the fourth day the child became for the first time conscious. Between the fourth and twenty-second days six similar injections were given. Until the twentieth day he improved in every respect, but on the twenty-second his general condition was not so favorable, and on the twenty-fourth day he died. At the necropsy the lungs alone presented appreciable lesion; diffuse and catarrhal pneumonia. The great improvement after the first four injections and the survival of the child for nearly a month seemed to be due to the serum. The cause of death in extensive burns is thought to be due to an autointoxication. Consequently, once the period of shock is passed, the treatment should be directed to freeing the system of the circulating toxin, and for this saline injections answer well. Due attention should also be paid to the emunctories, so as to still further favor the elimination of toxins.

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Azzarello divides the theories of the causes of death from burns into four classes: (1) death from shock or extreme pain; (2) embolism, thrombosis and destruction of the blood-elements; (3) pyæmic infection through the burnt surface; (4) poisons formed by the action of heat on the tissues or autointoxication from deficient excretion by the skin. By experimenting upon dogs and rabbits, it is personally claimed that the intoxication theory is the correct one. Injection of large quantities of artificial blood-serum subcutaneously appeared to save life in several cases.—*Monthly Cyclopedia of Practical Medicine.*

## THE TREATMENT OF PARAPHYMOSIS.

In treating paraphymosis most practitioners endeavor to produce retraction of the foreskin, and failing in this maneuvre, incise the stricture. A writer in the *Gazette des Hopitaux* recommends a simple measure, which is well worthy of practice before the severer one is adopted. He advises that two to five punctures be made with a bistoury in the swollen edematous prepuce, which should then be gently kneaded during three or four minutes. An abundant flow of serum, containing some or little blood, escapes, and immediately the integuments which were swollen and ready to burst become soft and slack. A slight taxis is then successful in restoring the parts to their natural position.

## THERAPEUTIC NOTES.

### Pruritus Ani and Vulvæ.

In pruritus ani and vulvæ the following formula will afford relief from the itching and irritation, to be applied locally:

| | | |
|---|---|---|
| ℞ | Sodii hyposulphis..... | 1 drachm. |
| | Acid, carbol..... | ½ drachm. |
| | Glycerinæ..... | 1 ounce. |
| | Listerine..... | 3 ounces. |

Mix.

### Uric-Acid Diathesis.

| | | |
|---|---|---|
| ℞ | Sodii bicarbonatis..... | gr. xlv. |
| | Acidi benzoici..... | gr. xv. |
| | Sodii phosphatis..... | gr. lxxx. |
| | Aq. bullient..... | ℥ iss. |

M. Solve et adde:

| | | |
|---|---|---|
| | Aq. cinnamomi..... | ℥ iij. |

S. Two teaspoonfuls three times daily.

—Golding Bird.

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# Jottings.

HOW TO STOP COUGHING.

The *Virginia Medical Semi-Monthly* correctly states that coughing is precisely like scratching a wound; so long as it is continued, the wound will not heal. Let a person, when tempted to cough, draw a long breath and hold it until it warms and soothes every air cell. The benefit will soon be apparent.

ORCHITIS.

Hyrarg. oleat.....ʒ iss.
Morphine sulph .....gr. iv.
Ol. gaultheria.....ʒ j.
Ol. olivæ, q.s. ad.....ʒ vi.

M. Ft. lin. Sig. Apply after bathing with hot water night and morning, and wrap testicles in absorbent cotton or flannel and have them suspended.

This prescription is also one of the finest in the world for sprains and rheumatism.—*Vail, Med. Sum.*

TO OVERCOME WHISKEY OR MORPHINE HABIT.—Dr. L. V. Weathers, Bracken, Texas, says (*Texas Med. Jour.*, April, 1900,) that a few drops of tincture of cinchona dropped far back on the tongue will at once overcome the craving for whiskey in a drinker.

He has used successfully the following for both whiskey and morphine craving:

℞ Ammon, bromid..... gr. v.
Fid. ext. belladon
" " nuc vomic.
" " cannabis Ind..... āā min. ij.
Water..... q. s. ʒij.

M. S.—Repeat same four times daily.

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THE
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# Editorial.

## WESTERN OPHTHALMOLOGIC AND OTO-LARYNGOLOGIC ASSOCIATION.

The Western Opthalmologic and Oto-Laryngologic Association held its fifth annual meeting at St. Louis, on the 5th, 6th and 7th of April. The President, Dr. W. Scheppergrell, of New Orleans, opened the meeting with a paper on "The Rise of Specialism," in which he disproved the oft-repeated charge that specialism in medicine are modern innovations. He cited historical data dating several centuries before Christ, in which distinct reference was made to specialists of the eyes, stomach and the head. The essayist commended specialists in medicine, as they promote more detailed study, and therefore lead to higher medical attainments.

J. W. Bullard, M.D., of Pawnee City, Neb., read a paper on "Two Classes of Eye Cases that Give Me a Great Deal of Trouble." Chief among them was those in which irritation and dryness of the conjunctiva persisted in spite of every attempt at refraction which had been made.

Edwin Pynchon, M.D., of Chicago, "Slight Irregularities of the Nasal Septum." The author advocated the removal or correction of slight irregularities of the septum when there were disturbances of the nasal functions on account of their presence. If later and larger development justified their

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removal, the author thought their early removal was justified on the grounds of "A stitch in time saves nine."

C. R. Holmes, M.D., Cincinnati, "Foreign Bodies of the Orbit, with Report of Cases." About seventy cases were compiled from the literature by the author, and three additional ones reported by him. The most interesting and unique case was one reported by the author. It consisted of a knife blade about 1½ inches long which had been in the orbit 32 years without causing much inconvenience. It was imbedded in a fibrous capsule and was but slightly rusted.

B. E. Freyer, M.D., Kansas City, "Report of a Case of Railway Trauma of the Eye, with the Report of a Case and Its Legal Aspect."

M. A. Goldstein. M.D., St. Louis, "Presentation of Cases; (*a*) Primary Tuberculosis of the Ear; (*b*) Primary Tuberculosis of the Larynx." (*a*) The case had been operated on some years previously and had a recurrence some months ago, at which time Dr. Goldstein did the Schwartz operation. Bad symptoms developed a few weeks ago and he did the radical operation, since which time the patient is doing well. (*b*) The second case was one of probable primary tuberculosis of the larnyx, which came under the observation of the author about one year ago. At that time he was in a very serious condition; death seemed but a matter of a few weeks or months. The patient was greatly emaciated, and in response to the treatment administered had gained a fair degree of health, being able to attend to business. The diagnosis in the case is somewhat doubtful, but the author having excluded luies and malignant growth, has made the diagnosis of primary laryngeal tuberculosis. Tubercle bacilli are absent, and the tissue has not been examined m croscopically.

Dr. Wm. L. Ballenger, of Chicago, "The Physiologic Tests of the Organs of Hearing as Aids in the Differential Diagnosis of Lesions of the Ear." The author advocated the physiologic tests of the ear, including the range of hearing, as tested with the tuning fork, Galton whistle, the Webber experiment, the Rinne experiment, the Schwaback and Bing tests, as important aids in the differential diagnosis of the

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lesions of the ear. They are of special importance in determining the location of the lesion. He suggested that in a general way the deeper the structure involved, the more pronounced the disturbance of hearing and the less probability of a cure. The tests were, therefore, recommended more for the purpose of aiding the surgeon in giving a correct diagnosis than for the purpose of aiding him in the treatment, which is often unsuccessful. Six cases were cited illustrating lesions of different kinds in the middle ear and labyrinth in which the tests were used for the purpose of differentiating them. He recommended that the tests be made in all cases of ear disease in which there was marked deafness and tinnitus, both before and after inflation of the tympanum. If this point is neglected the diagnosis may not be properly made. While the physiologic tests are not absolute guides to a correct diagnosis, they are, together with all the other means of diagnosis, the most correct at the command of the aural surgeon, and, therefore, should be invariably used.

O. J. Stein, M.D., Chicago, "Symetrical Osteoma of the Nose; Report of a Case." The author reported a very rare case of symetrical or double osteoma of the nose, occluding the nasal chambers and extending to either side for a considerable distance, whereby the patient was given the typical frog-face appearance. Osteoma upon one side is rather common. This case was presented on account of its unique type, and was reported with a number of other cases collected from the literature. No attempt was made to correct the deformity, as the patient is well advanced with tuberculosis, several other members of the family having died with the same disease.

Jno. J. Kyle, M.D., Indianapolis, "The Sympathetic Inflammation and Sympathetic Irritation of the Eye." The author made an interesting review of the subject presented, in which he advocated the usual classical treatment.

Adolph Alt, M.D., St. Louis, "Studies Concerning the Anatomy of the Eye Lids, Especially Their Glands (with lantern slides)." The purpose of the author was to report the result of an extensive examination made of the tissues of the eye lids, in which he had found mucous glands located in positions where they were not usually found. He also stated

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that in all his examinations, with one exception, the torsal cartilages of the eye lids were not true cartilaginous tissue.

W. H. Loeb, M.D., St. Louis, "Presentation of Specimen of 107 Polypi Removed at One Sitting." This case was unique, not so much on account of the great number of polypi removed from the nose, as from the fact that they were removed at a single sitting. They were uniformly pedunculated and varied greatly in size.

## THE INTERNAL USE OF WATER.

To quench thirst there is no fluid comparable to clear, filtered water. As a keeper of health and a restorer to health, in many minor diseases, we believe it is not used as freely as it should be. The sewers of towns and cities are not flushed, except by heavy rain storms, as freely as common sense tells us they ought. Often they are choked, and are the source from which disease attacks a community. The sewers of the human body are the bowels, the kidneys and the lungs. These are the organs by which the waste material is got rid of. Water very materially assists them in carrying out their functions, for it holds much of the *debris* material in solution. It keeps up to its full proportion the amount required for the blood to perform its function, and it stimulates glandular action. Many hepatic diseases can be benefited by copious drinking of water. Now that we are entering upon the hot season, the body will call loudly for water, and it should be freely allowed. The medical profession will shortly be sending their rheumatic patients to the numerous springs, celebrated as resorts for this class of diseases. They will be instructed to drink of the "water" freely, and the advice will be followed, sometimes we think, too freely. A patient who cannot be induced to drink daily half a dozen glasses of water at home will willingly drink twenty at the springs. The result is beneficial, not so much because of the various salts found in the "spring's" water, but on account of the flushing which the sewers of the body undergo. The surroundings at these resorts are also beneficial, the eye is rested, and through it the entire system is benefited. Copious drinking of water prevents overfeeding, and thus important

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organ gets a much needed rest. There are, however, a large army of sufferers who cannot afford the luxury of visiting these health resorts. Such, however, can receive benefit at home by drinking freely of water. Human nature is, however, distrustful of such a simple remedy. He must get specific directions to take so many glasses daily, and the chances of his carrying out such treatment will be largely increased by giving him a small alkaline powder to be dissolved in each glass. He will then believe that he is taking medicine, for that is what man craves for. If you wont give it to him someone else will.

## DR OSLER AND THE UNIVERSITY OF EDINBURGH.

It is announced by the *British Medical Journal*, on authority, that Dr. Osler, of the Johns Hopkins University, Baltimore, is not an applicant for the Chair of Medicine in the University of Edinburgh.

## ANNUAL CONVOCATION OF THE MEDICAL AND DENTAL FACULTIES, UNIVERSITY OF BISHOP'S COLLEGE.

The twenty-ninth Annual Convocation of the Medical Faculty of the University of Bishop's College, and that of the Dental Department, was held in the Synod Hall, Montreal, on the 26th of April. The day was beautiful and there was a large turn out of the friends of the Faculty, the large hall being crowded in every part. The chair was taken shortly after three o'clock by Chancellor Heneker, who was supported on the platform by Acting Principal Allnatt and the various members of the Medical and Dental Faculties. The Dean, Dr. F. W. Campbell, made the usual announcements, and the candidates for the degree of C.M., M.D., and that of D.D.S. were presented by the Deans. The following ladies and gentlemen received the degrees of C.M., M.D. :

Francis Oscar Anderson, Montreal; Albert Cuff Lopez, Manderville, Jamaica, W.I.; Miss Mary Adelaide Runnels, Milton, P.Q.; Alexander Macdonald, Scotstown, P.Q.; Miss

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Margaret Jane Currie, Montreal; Christopher Healy Christie, Montreal; John Albin Hamilton, Montreal; Frederick Wilmot Mann, Maine, U.S.; Joseph William Davis, Windsor, Ont.

To those students who had distinguished themselves by winning prizes and medals, hearty applause was accorded as they stepped forward to receive awards, viz.:—Histology, W. H. Still; first year practical anatomy, Jas. McGregor; second year practical anatomy, E. H. Brown; David silver medal, Miss Florence Evans; Chancellor's prize, A. C. Lopez; Wood gold medal, F. O. Anderson.

The following gentlemen received the degree of D.D.S., being presented to the Chancellor by Dean Kerr, of the Dental Faculty:

G. H. A. Stevenson, F. W. McKenna, F. E. Skinner, J. B. Morrison, William Watson.

The Chancellor then addressed the audience, after which the convocation was declared closed.

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## HYDROPHOBIA.

The Chicago Pasteur Institute has published a brief report of its work since its organization, July 2, 1890. Number of patients treated, 780. 709 persons were bitten by dogs, 29 by cats, 26 by horses, 7 by skunks, 5 by wolves, 2 by cows, 1 by calf, 1 by rat, 1 by mule, 1 by pig and 3 by hydrophobic individuals. 268 were persons who had been bitten by animals known positively to have been rabid, 358 were bitten by animals recognized as rabid by their symptoms, and 161 were bitten by animals strongly suspected as infected with rabies. Three deaths are reported, a mortality of 0.38 per cent. Before the Pasteur treatment the mortality was 88 per cent. for bites of the face, 67 per cent. for bites of the hands, and 30 per cent. for bites in other portions of the body. Of the number treated 377 persons suffered from severe and multiple bites on hands and wrists, 92 on head and face, 110 on arms, 173 on legs and thighs and 28 on trunk. The report is certainly a very gratifying one for the Institute and an excellent testimonial to the eminent scientist who established this mode of treatment.

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# PERSONAL.

Dr. Walker, M.D., Bishop's, 1895, of Menomee, Mich., has recently married—a sign that hs is meeting with good success—which we are informed is the fact. We also hear that he proposes in the near future to devote himself to the eye, ear, nose and throat.

Dr. Addison, M.D., Bishop's, 1896, has ever since his graduation been practising in Marinette, Wisconsin. He has met with almost phenomenal success, and proposes in the near future to pay a visit to his old home in Tasmania.

Dr. Fairfield, M.D., Bishop's, 1887, is still at Green Bay, Wisconsin, where his success has been marked. He found his instruction at the Women's hospital of immense advantage to him when he began to practice.

Dr. H. B. Chandler, M.D., Bishop's, 1880, has just been appointed Professor of Ophthalmology at Tafts Medical school, Boston. This medical school has a very large Eastern patronage, and occupies a high position among the medical colleges of the United States. The Faculty have recently paid $180,000 for a lot on the Back Bay, on which it is proposed to erect the finest and best equipped medical building in America.

Dr. Webb, M.D., Bishop's, 1897, has settled in Cambridge, Mass., and has met with success sufficient to determine it as his permanent home.

We had the pleasure recently of having luncheon with Dr. Wolfrid Nelson, C.M., M.D., Bishop's, 1872, at the Astor house, New York, where he has his office and resides. Dr. Nelson is surely drawing around him a good clientele, and is employed by a number of life insurance companies as special medical examiner. Dr. Nelson is one of the leading Canadians in New York, and occupies the position of vice-president of the Canadian society.

Dr. Ford, M.D., Bishop's, 1898, is surgeon of the Elder-Dempster royal mail steamship "Lake Superior," sailing between Montreal and Liverpool.

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# Book Reviews.

**Progressive Medicine.** A quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences, edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, Philadelphia, assisted by Charles Adams Holder, M.D., Assistant Demonstrator of Therapeutics in the Jefferson Medical College. Vol. 1, March, 1900. Lea Bros. & Co., Philadelphia and New York.

This volume reaches us promptly on time, and continues to be filled with well made selections on the principal subjects which have received the attention of professional workers during the preceding quarter. A somewhat close scrutiny reveals the fact that the profession is still being deluged with a mass of theoretical pabulum, which, while destroying much that has been considered sound and orthodox, does not replace it with material of a similar kind. The present volume embraces the Surgery of the Head, Neck and Chest, which has been collated by such a well known man as Dr. J. C. Da Costa; Infectious Diseases, including Acute Rheumatism, Croupous Pneumonia and Influenza, by Dr. Packard. The Diseases of Children have shown up well under the direction of Dr. Blackader, of Montreal; Pathology, by Dr. Hektven; Laryngology, by Dr. A. Logan Turner, and Otology, by Dr. Randolph.

The style in which this work is being produced is deserving of special acknowledgment. The type is of good size, causing no straining of the eye, and the paper is beautifully white and clear, and entire absence of gloss. It is handsomely bound, and makes an elegant addition to any library. F. W. C.

**Injuries to the Eye in their Medico-Legal Aspect.** By S. Baudry, M.D. Professor in the Faculty of Medicine, University of Lille, France, etc. Translated from the original by Alfred James Ostheimer, Jr., M.D., of Philadelphia, Pa. Revised and edited by Charles A. Oliver, A.M., M.D., Attending Surgeon to the Wills Eye Hospital; Ophthalmic Surgeon to the Philadelphia Hospital; Member of the American and French Ophthalmological Societies, etc. With an adaptation of the Medico-Legal Chapter to the Courts of the United States of America, by Charles Sinkler, Esq., Member of the Philadelphia Bar. 5⅝ x 7⅞ inches. Pages, x–161. Extra cloth, $1, net. The F. A. Davis Co., publishers, 1914-16 Cherry street, Philadelphia, Pa.

This book comes to us most opportunely in these days when Mutual Benefit Societies are so numerous and insurance against accidental injury either in such societies or in the regular insurance companies is the rule among that part of the population engaged in industrial pursuits. Cases of persons so insured claiming in-

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demnity for accidental injuries to the eye are constantly being brought to the oculist for a decision as to the duration of the resulting disability, the gravity of the injury, its effect on the wage-earning power of the insured, etc., etc. Dr. Baudry's book gives us in a clear and compact form what is known with regard to diagnosis and prognosis of such injuries, with an excellent chapter on the best means of detecting simulation.

A full bibliography, and numerous illustrative cases taken from the author's practice, add to the value and interest of the book.

The general principles laid down in the chapter devoted to medico-legal evidence apply everywhere, although legal procedure in this province differs largely from that of other countries.

G. W. M.

**Essentials of Surgery**, arranged in the form of Questions and Answers, by Edward Martin, A.M., M.D., Clinical Professor of Genito-urinary Diseases in the University of Pennsylvania. Seventh edition, revised and enlarged. Publishers, W. B. Saunders, Philadelphia. Price, cloth, $1.

This little book is very cleverly prepared, and is most concise and to the point. While it is too brief for the student, who is in the habit of making a thorough study of his subject, yet as a rapid reference for some half-forgotten point or a hurried review of a subject it is certainly excellent. It is very complete on all the branches of surgery, and the chapter on bandaging is nicely illustrated. The other illustrations throughout the book are appropriate. An appendix of receipts and antiseptic methods of preparing ligatures, dressings, etc., is very well arranged, and contains many useful hints.

G. F.

**Diseases of the Throat and Nose.** By J. Price Brown, M.B., etc., of Toronto. F. A. Davis Co., publishers, Philadelphia.

This important book has been prepared particularly for the assistance and guidance of practitioners who cannot send all their patients to the specialist of acknowledged skill. There are many, in fact the great majority of patients with ailments in the region of throat and nose who are too poor to pay more than a small fee, hence the author aims at aiding the practitioner to better understand and treat such special work. There is omitted such subjects as are treated fully in the more classical specialists' text-book, as the descriptive anatomy of the parts, and this is only touched upon so far as it relates to the practical treatment of diseases of these organs.

The book is restricted within certain lines because of the desire to enter—as fully as space would permit—into the many questions within its range, and to do so in accordance with the most recent scientific investigations, bringing the record down to the immediate present. The metrical system, which we must all adopt sooner or later, has been adopted.

The book is very freely illustrated with clear plates, the colored and Indian ink illustrations deserving special mention. Altogether we regard the production as a worthy addition to the many volumes already presented to the medical public on this subject.

G. T. R.

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**The Anatomy of the Brain.** A text-book for medical students, by Richard H. Whitehead, M.D., Professor of Anatomy in the University of N. Carolina. Illustrated with 41 engravings ; 96 pages. Cloth, $1.00. Publishers, The F. A. Davis Co., Philadelphia.

This work is suitable for students of Brain Anatomy, being clear, concise and untrammeled with those subjects which are still matters of controversy. The first chapter considers the embryology of the nervous system, thus explaining the origin of the five parts of the encephalon. The text is very brief in describing the various anatomal structures throughout, and does not supplement the bare anatomical facts by comparative descriptions or physiological functions so valuable in aiding the student to assimilate this difficult subject.

We are pleased to note that the Latin terms adopted by the German Anatomical Society have been inserted parenthetically after the name commonly used in this country.

G. F.

**A Dictionary of Terms Used in Medicine and the Collateral Sciences.** By Richard D. Hoblyn, M.A., Oxon. Thirteenth edition, revised thoroughly, with numerous additions by John A. Price, B.A.,M.D., Oxon, late Physician to the Royal Hospital for Children and Women. Lea Brothers, & Co., Philadelphia and New York, 1900.

This is a volume of almost nine hundred pages, printed in easily-read type, and is fully up to date, embracing practically all, or nearly all, the terms relating to Bacteriology. This last has been materially added to since the publication of the last edition. It is got up in very convenient size, and the fact that it has gone through twelve editions is an evidence that the medical profession has found it meets their wants.

F. W. C.

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CANADA
MEDICAL RECORD

JUNE, 1900

# Original Communications.

## PROGRESS OF GYNECOLOGY.

By A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., Eng.

Fellow of the British and American Gynecological Societies; Professor of Clinical Gynecology in Bishop's University; Gynecologist to the Montreal Dispensary and to the Samaritan Hospital; Surgeon to the Western Hospital and Consulting Gynecologist to the Women's Hospital.

*Appendicitis as a complication of pelvic disease.* A number of papers have recently been read on this subject, among the most important being one by Dr. McLaren, of St. Paul, at the meeting of the American Gynecological Society at Washington in May. It has been pointed out that dysmenorrhœa, which is a common disease in young girls, is frequently due to disease of the tubes; secondly, that disease of the tubes is often due to infection from the vermiform appendix; and thirdly, that disease of the vermiform appendix or appendicitis is always due to infection by the color bacillus, and that the color bacillus increases in numbers in proportion to the length of time the bowels remain unmoved. My own experience in over a hundred operations for pus tubes quite bear out this theory; for in about fifteen cases the vermiform appendix was adherent to the right tube and in one case to the left tube, and in nearly all there was severe dysmenorrhœa. Although gonorrhœa was the principal cause of the pus tubes, yet in some of the cases there was no possibility of this being the case as they were young girls of irreproachable character. Many of these cases occurred in the practice of *confrères* who called me in consultation; in some of them appendicitis had been.

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diagnosed and in others salpingitis, but at the operation both conditions were found to be present, so that there was no mistake in the diagnosis. The lesson to be learned is that the first thing to do in treating dysmenorrhœa and inflammation of the right side of the pelvis is to have the bowels thoroughly moved. No reliance must be placed on enemas for this purpose as they only empty the rectum. Ten grains of calomel followed in five hours by a saline. Several cases have recently been reported where all arrangements had been made for removing the appendix, but as soon as the calomel and saline had moved the bowels the patient rapidly got well. However, when a patient has had more than one attack, however slight, she should have the appendix removed soon after recovering from the second attack, while in severe attacks incision and drainage should be done within twenty-four hours.

Several cases have been reported in the journals where immediate recovery followed this method without breaking up the wall of adhesions which nature almost always throws up to save the general peritoneal cavity from infection. Many other cases are recorded where these adhesions were broken up in the endeavor to be very thorough in the effort to remove the remains of the appendix, and in all of them the patient died.

*Vaginal hysterectomy for procidentia.* Although it is not very certain for how many thousands of years the womb has been falling out of the body, it is probable that it was the first gynecological disease to receive treatment. Of course until within the last ten or twenty years the relief obtained by pessaries was only partial, because, as a rule, the perineum was torn, and the outlet of the vagina at the vulva was as large as any other part of it, so that it was difficult to keep any support in. Large ring pessaries, and stem and cup pessaries held in by a perineal bandage were the most effective, but were very inconvenient, while sometimes quite dangerous owing to the cutting of the pessary through the vagina into the peritoneal cavity. The present methods are much more satisfactory, and have the merit of effecting a

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complete cure. We have two operations to choose from according to the degree of prolapse and the size of the uterus. If the uterus is small and not far enough out of the body to have become ulcerated, the safest operation is to make a small incision in the abdomen, and catching the fundus with bullet forceps draw it up to the meatus and scarify the whole anterior surface of the fundus, and then sew it to the abdominal wall with buried chromicized catgut. Then to close up the vaginal outlet by a large posterior colporhaphy. If, however, the uterus is very long (sometimes it is seven or eight inches deep), and especially if it is ulcerated, it is better to perform vaginal hysterectomy, and after bringing the stumps of the broad ligaments together to sew up the roof of the vagina and then to close up the perineum. The objection is often raised that the woman is too old to undergo such operations, but I have found by experience in many cases that there is no foundation for the objection. The two last cases of this kind I operated at the Western Hospital a week ago and two weeks ago respectively on women sixty-five years and seventy-five years of age. In the first one I had already done ventrofixation three months ago followed by colporhaphy at the same sitting; but the uterus was so long that when the fundus was attached high up on the abdominal wall, half way to the umbilicus, the cervical end with the vagina was at the vulva In this case I removed the lower four inches of the uterus, and sewed the vagina to the cervical canal remaining. The result seems to be good. In the second case, age seventy-five, there was a large malignant-looking ulcer on the cervix, due to the cervix sticking to the clothing when she sat down, and I therefore removed the whole uterus, which was about five inches long, and closed the perineum. Although the arteries were very hard and there was an arcux senilis, she bore the operations remarkably well; she was only on the table half an hour for the two operations, and did not lose more than three ounces of blood, most of which was during the perineoraphy. She is quite convalescent with a pulse of eighty. The result promises to be very satisfactory.

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# HISTORY OF THE FORMATION OF THE MEDICAL FACULTY OF THE UNIVERSITY OF BISHOP'S COLLEGE.

By FRANCIS W. CAMPBELL, M.A., M.D., L.R.C.P., London, D. C. L., Dean, Faculty of Medicine, University of Bishop's College.

Those who in the early part of the present century established in Montreal the first Medical School in Canada, now the Faculty of Medicine of McGill University, were far-seeing men. The future of Montreal, as a centre for Medical education was evidently not beyond the horiscope of their vision. Events have thoroughly proved the wisdom of the action which they took and persevered in, often, no doubt, amidst much discouragement. A few years later, in 1845, the Montreal School of Medicine was incorporated, and its lectures were delivered in both the French and English languages. This system of double lectures was found not to work satisfactorily and was discontinued. It then became what it is to-day, the medical educational institution for our French speaking confreres. During its history it has in turn been simply a teaching body or School, a Faculty of Victoria University, Cobourg, and now is a Faculty of Laval University.

Such was the position of Medical teaching in Montreal in 1851—This was before my day, but I can imagine existing lines to have been then, as I know them to have been twenty years later. It was this condition which induced the formation of the St. Lawrence School of Medicine, a copy of whose first and only announcement was as follows:—

## ST. LAWRENCE SCHOOL of MEDICINE of MONTREAL.

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| Midwifery and Diseases of Women and Children. | F. C. T. ARNOLDI, M.D., late Lecturer on Midwifery, School of Medicine, and on Medical Jurisprudence McGill College. Surgeon Montreal General Hospital, and member of the Board of Examiners College of Physicians and Surgeons, L. C. |
| Institutes of Medicine, Physiology, Pathology and Therapeutics. | GEORGE D. GIBB, M.D., L.R.C.S.I., Physician to the Montreal Dispensary. |

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| Theory and Practice of Surgery. | R. L. MacDonnell, M.D., L.K., Q.C.P. and R.C. S.I., late lecturer on Institutes of Medicine, and on Clinical Medicine, McGill College, late Surgeon to the Montreal General Hospital. |
| Anatomy, Descriptive and Surgical. | THOMAS WALTER JONES, M.D., L.R.C.S.E. |
| Theory and Practice of Medicine. | A. H. DAVID, M.D., L.R.C.S.E., Physician to the Montreal General Hospital, Member of the Board of Examiners College of Physicians and Surgeons, L. C. |
| Materia Medica and Pharmacy. | GEORGE E. FENWICK, M.D., Physician to the Montreal Dispensary, late Curator to the Museum, McGill College. |
| Ophthalmic and Aural Surgery. | HENRY HOWARD, M.R.C.S.I., Surgeon to the Montreal Eye and Ear Institution. |
| Chemistry. | ROBERT PALMER HOWARD, M.D., L.R.C. S.E., Physician the Montreal Dispensary. |
| Botany. | * * * * * * |
| Clinical Medicine. | At the Montreal General Hospital by Dr. DAVID. |
| Clinical Surgery. | At the Montreal General Hospital by Dr. ARNOLDI. |
| Comparative Anatomy and Zoology. | Dr. GIBB. |

Anatomy being the basis of Medicine and Surgery special care will be devoted to its cultivation, and every facility will be afforded the pupil by dissections and demonstrations; and in order to enable him to prosecute his studies in this department more profitably, the dissecting rooms will be lighted with gas and will be kept open from 6 A.M. to 11 P.M. daily, during which time competent demonstrators will attend to superintend the pupils.

The business of this School will be carried on in a commodious building, situate in the immediate vicinity of the Montreal General Hospital, containing a large theatre, spacious and well ventilated dissecting rooms, and a Museum of Human and Comparative Anatomy and Pathology.

Five lectures will be delivered weekly throughout the

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session, on each branch (excepting Forensic Medicine, Clinical Medicine, Clinical Surgery, Ophthalmic and Aural Surgery, Botany and Comparative Anatomy and Zoology, each of which will be a three months Course) from 1st November to end of April, in conformity with the rules of the College of Physicians and Surgeons of Lower Canada. They will be illustrated by numerous preparations, a large collection of plates, drawings, models and casts; and the recent discoveries in Physiology and Pathology will be practically taught by means of Achromatic Microscopes by the Lecturers on these branches.

Ample opportunities for Midwifery practice will be afforded to the Senior students in that branch, under the immediate superintendence of the Lecturer.

Students attending the lectures on Ophthalmic and Aural Surgery will have the privilege of witnessing the practice at the Montreal Eye and Ear Institution, during the session.

Board and lodging can be obtained at moderate rates in the vicinity of the School.

The fees for the lectures will be the same as at the University of McGill College.

For further particulars apply to

A. H. DAVID, M.D.
Secretary.

N. B.—The certificates of this School being recognized by all the principal Colleges in Great Britain and the United States, it will be to the advantage of students intending to complete their professional education in either of these countries, to attend the courses of lectures of this school.

The St. Lawrence School of Medicine only existed for one session. The cause which, it is said, terminated its existence should have prevented its birth. This was the fact that it could not compete on equal terms with McGill University. —The graduates from McGill received their license from the College of Physicians and Surgeons of Lower Canada, without further examination as to their knowledge and skill.

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Those whose Medical course would have been completed at the St. Lawrence School, had it lived and requiring the Provincial License, would have had to present themselves before the College of Physicians and Surgeons of Lower Canada for examination on all the branches of Medical Science. The examiners of this Board were, many of them, Professors in McGill. I have been told by several who were Lecturers in the St. Lawrence School, that it was not considered either wise or fair to submit the chance of their students getting fair play from a Board largely composed of rival Professors. With the termination of its first session—the St. Lawrence School of Medicine therefore closed its doors.

The spirit, however, which had brought to life this School did not die. On the contrary it continued to grow and gain force, and when I entered upon my professional life in 1862 in the city of Montreal, I found among many a feeling of the necessity for a new, or if you like the word better, an opposition School of Medicine in this city. Various reasons may be assigned for this feeling, and they may briefly be epitomised as follows:—(1) A desire to have an up-to-date School, for the only existing English School had been for years running in the groove, which it had long followed, some subjects taught in England and the United States or more elaborately taught, not yet having been added to its curriculum. (2) A feeling that the members of the profession, outside of this school, had no chance to secure Hospital and other appointments—for when vacancies for these occurred, candidates from the outside profession were met with the united opposition of this School. (3) This same opposition was evident in private practice, and gave rise to numerous heart burnings. It was felt that the formation of a new Medical School would afford an opportunity of at least attempting to rectify some of these grievances, and if successful place the profession generally in a more satisfactory condition. It was very generally expressed that a new School would be beneficial in many ways, and that McGill had not preoccupied every avenue to science. How keen this feeling was, even at the foundation of the "School of Medicine

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and Surgery," will be understood by the following lines taken from the lecture delivered at its opening by Dr. Sutherland: "What exclusive right is possessed by this Faculty? What species of idolatry is it which ought to enforce us to blindly worship the memory of its departed founders, in permitting their representatives to hold within an iron grasp all the reputation derivable from such a source. What has rendered this place a shrine at which they alone are to receive homage." I found this feeling strong in 1862, I saw it grow year by year until in 1871 it culminated in the formation of the Medical Faculty of Bishop's College. This new teaching body was free from the central point of weakness which had wrecked the St. Lawrence School of Medicine. It was, like the Medical School of McGill, the Faculty of a University. The early history of this Faculty of Medicine, and of its creation may not as yet possess the interest which attaches to older institutions. It is however advisable that its history should be written while some of those who participated in its formation are still alive. When time shall have given antiquity to an institution still in its youth—but a youth of vigour, energy, and promise, it doubtless will be surrounded by hosts of friends. These will realise and we believe appreciate the untiring, unpaid energy and determination of its founders, who brushed aside all obstacles, till success rewarded their efforts. In January 1871, Dr. Charles Smallwood, Dr. Hingston, Dr. A. H. David, and Dr. E. H. Trenholme, met and discussed the formation of a School of Medicine in Montreal, in connection with the University of Bishop's College, Lennoxville. The decision being in the affirmative, it was decided to ask me to assist them in the work. Having accepted the proposal, I attended a meeting at Dr. David's house in Beaver Hall Terrace, on the evening of 1st February, 1871, when the four gentlemen named above were present: The following telegram was read:

St. Hilaire, February 1, 1871.

To Dr. Hingston:

More particulars of Medical Corporation required, give them in person, it will hasten matters,

*Signed*, T. E. Campbell.

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Major Campbell, C.B, who signed this telegram was Seignior at St. Hilaire, and a warm friend of Bishop's College up to his death in August, 1872. He was a lineal descendant of the Campbells of Inverawe, and served in several Imperial Regiments, his last I believe being the 7th Hussars. The Faculty of Medicine of Bishop's College owe to him a debt of gratitude for the active interest he took in its formation.

It was decided to send Dr. David to Lennoxville, and he accordingly left that night, to lay before the Board of Trustees a proposition for the establishment of a Medical School in Montreal, in connection with the University of Bishop's College. On the 3rd of February, Dr. David reported to the above five named gentlemen that his interview with the Board of Trustees of Bishop's College had been very satisfactory—the following resolution having been passed by them:

"That it is the unanimous opinion of the gentlemen present at this meeting . . . . that the proposal to affiliate to the University the Medical School about to be formed in Montreal, consisting of . . . . and others, is one of the highest importance to the University, and with this view the gentlemen now present will request the President of the Corporation at the earliest possible period to call a meeting of the Corporation to consider this proposal."

On the 9th of March, 1871, a special meeting of the Corporation of Bishop's College was held in the Cathedral school-house (now Synod Hall), the Hon. Edward Hale, Chancellor of the University, being in the chair. A motion accepting the offer of the proposed Medical School, and that it go into operation not later than the following October, was unanimously passed.

The following gentlemen were then appointed Professors in the Medical Faculty of Bishop's College: Charles Smallwood, M.D., LL.D., D.C.L., Professor of Midwifery; A. H. David, M.D., Edin., L.R.C.S., Edin., Professor of the Theory and Practice of Medicine; William H. Hingston,

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M.D., L.R.C.S., Edin., Professor of Surgery; Francis Wayland Campbell, M.D., L.R.C.P., London, Professor of Institutes of Medicine; Edward H. Trenholme, M.D., B.C.L., Professor of Materia Medica. Dr. Smallwood was named Dean and Dr. F. W. Campbell, Registrar, at a meeting of the new Faculty held on the 14th of March at Dr. Hingston's house.

On the 18th of March at a Faculty meeting, a code of rules for its government was adopted. The only rule worthy of special mention was the following: "Should the resignation of any professor be deemed advantageous to the interest of the School, he shall, upon the written request to do so of any six of his colleagues, resign forthwith his appointment." From this date till the 7th of June, the Faculty was engaged in the work of completing its formation. On this day it struck its first shoal, by Dr. Smallwood severing his connection with it, on account of having "received an appointment from the Signal Office of the United States War Department, and also from the Hon. Minister of Marine and Fisheries," which would occupy all his spare time. The resignation was accepted and Dr. Hingston elected Dean in his place. At the annual Convocation of the University held at Lennoxville, in the latter part of June, the Faculty attended, each member receiving the degree of M.A. *honoris causa*. The end of July the Faculty issued its first annual announcements, which created no small excitement, as it had been hoped by many that the efforts which had been put forth to strangle its birth would have been successful.

The Faculty at the time stood as follows:

Wm. H. Hingston, M. D., L. R. C. S. E., D. C. L., Prof. Principles and Pratice of Surgery, Dean of the Faculty.

Aaron H. David, M. D., Edin. L. R. C. S. E., D. C. L., Prof. Theory and Pratice of Medicine.

Robert T. Godfrey, M. A., M. D., Prof. of Midwifery and Diseases of Women and Children.

Jean Lukin Leprohon, M. A., M. D., Prof. of Hygiene.

Francis W. Campbell, M. A., M. D., L. R. C. P., Lond. Prof. of Institutes of Medicine, Registrar of Faculty.

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Edward H. Trenholme, M. A., M. D., B. C. L., Prof. of Materia Medica and Therapeutics.

J. Baker Edwards, M. A., Ph. D., D. C. L., Prof. of Chemistry, Practical Chemistry, and Microscopy.

Richard A. Kennedy, M. A., M. D.. Prof. of Anatomy.

William Gardner, M. A., M. D., Prof. of Medical Jurisprudence.

George Wilkins, M A., M. D., Prof. of Pathology.

Silas E. Tabb, M. A., M. D., Prof. of Botany.

James Perrigo, M. A., M. D., M. R. C. S. Eng., Demonstrator of Anatomy and Curator of Museum.

The second vicissitude of the Faculty came about soon after its first announcement was issued, and was the withdrawal of Dr. Hingston (now Sir William Hingston) from the Deanship and Professorship of Surgery, this action on his part having become necessary in order to retain his connection with his Hospital (the Hotel Dieu). It appears that many years previously the medical control of this hospital was, by notarial deed, placed in the hands of the Montreal School of Medicine (at this time affiliated with Victoria College, Cobourg, Ont.). On the announcement of the Medical Faculty of Bishop's College being placed in the hands of the public, Dr. Hingston was notified by the Montreal School through its Secretary, the late Dr. Pelletier, that he must sever his connection with Bishop's College, or his connection with the Hotel Dieu would cease on a date named. The future of the new School was, of course, uncertain, and after weighing well the *pour et contre*, he determined, with deep regret, to withdraw. I need hardly say that the Faculty felt that Dr. Hingston's retirement was a severe blow. Several meetings were held, and the situation thoroughly and thoughtfully discussed. The decision was to proceed and prepare for the opening of the School in October. Dr. David was elected Dean and Dr. Godfrey was transferred to the chair of Surgery, Dr. Trenholme to that of Midwifery, and Dr. Kollmyer was taken into the School and elected Professor of Materia Medica. The future being now clear, the Faculty began to look around for a building in which to carry on its work. In this search great difficulty was experienced, as several buildings, which were

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deemed suitable, were refused by their proprietors to be rented for such a purpose. At last a top flat was secured in a building on the northeast corner of McGill and Notre Dame streets, it being sub-leased from the Chemists' Association. The date for opening the school was fixed for the 4th of October, 1871, and the opening lecture to be delivered by the Dean, Dr. David. This fact was duly advertised, also that the Registration book was open. The first name entered upon it was Wolfred Nelson, a son of the late Dr. Horace Nelson, and a grandson of the late Dr. Wolfred Nelson, an ex-Mayor of Montreal and well known in Canadian political life. The opening lecture was delivered on the date named. The audience was not large, but among those present was the late Dr. William Sutherland, Professor of Chemistry in McGill University. Work was then commenced and the lectures regularly delivered, and the dissecting-room opened. Many interesting anecdotes of this first session might be given, but they would occupy too much space; one will suffice. My class for the first two weeks consisted of two students, viz., Mr. Richmond Spencer, and Mr. Robert Costigan. About the end of the second week, on arriving to deliver my lecture, I found that my class had diminished by one-half. Mr. Robert Costigan was absent. I was told he had been induced to leave and go to McGill College. Depressed by this desertion, but not discouraged, I lectured for a whole week to the remaining member of the class, when Mr. Costigan returned to his first love. He attended the College for three years, and graduated M.D. from Bishop's, April, 1874. The means used to detach Mr. Costigan were not fair. I will not say more, though the details are as clear in my mind to-day as if they had occurred but yesterday.

By the time the registration book closed in December, twenty-five students had registered their names. On the 4th of April, 1872, the first Convocation of the Faculty took place at Lennoxville, the Chancellor of the University, the late Hon. Edward Hale, conferring degrees. The entire

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Faculty were present. The following are the names of the first graduating class:—

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| Wolfred D. E. Nelson, | Montreal, Que. |
| Henry S. Cunningham, | St. Catharines, Ont. |
| Philippe Desilets, | Three Rivers, Que. |
| Joseph F. A. Lanouette, | Champlain, Que. |
| Andre Latour, | Lachine, Que. |
| Richard Webber, | Richmond, Que. |

The first session was considered as being more than satisfactory. As a result of this success, the idea of erecting a building for occupation by the School was mooted and seriously discussed. There were difficulties in the way—financial difficulties, of course. These were soon relieved by a generous offer on the part of Dr. Godfrey, our Professor of Surgery, to erect such a building as the School required, on the Faculty agreeing to pay interest on the cost. I need hardly say that this offer was accepted. Plans were prepared and discussed and finally adopted. That such an idea had very early in the history of the Faculty taken root, is proved by the fact that Dr. Hingston had secured for this purpose a lot of ground on the corner of Mance and Ontario Sts. This land was purchased by Dr. Godfrey, and work was commenced on the building. Although not completed, yet it was in such a forward state, that the second session opened on time within its walls, the introductory lecture being delivered by me. The session showed a registered class of thirty stud ents being an increase of five over the previous year. This was considered a satisfactory showing, seeing that this faculty was competing for students on an advanced schedule. By this I mean that we were teaching subjects which up to that time had not been included, as distinct branches, in any Medical School in the Dominion. These were, Pathology by Dr. Wilkins, Hygiene, by Dr. Leprohon, and Practical Chemistry by Dr. J. Baker Edwards. Subsequently—within a year or two—Dr. Wilkins took up Practical Physiology and Histology. In 1877, Dr. O. C. Wood of Ottawa, through his son, Dr. C. A. Wood, a graduate of the College, offered a

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Gold Medal, to be known as the "Wood Medal," to be competed for annually on the following terms:—1st, Competitors must attend at least two sessions at Bishop's College; 2nd, 75 per cent of the whole number of marks must be taken—including all subjects; 3rd, If the graduating class, at any time be less than four, the Medal may be withheld, unless the Faculty thought that the best man had shown such excellence, that he was deserving of it. Dr. O. C. Wood having died, Dr. C. A. Wood has donated the sum of $1000, which is invested to produce the Medal yearly.

In 1880, Dr. C. E. Nelson of New York founded the "Robert Nelson" Gold Medal. For this purpose he donated the sum of one thousand dollars. The Medal was in commemoration of his father, Dr. Robert Nelson, who began his medical career in Montreal, where he obtained special eminence in surgery. He subsequently removed to New York, where he died. This Medal, was donated as a special prize in Surgery, and for it there was to be a special examination, which must be written, oral, and the performance of operations on the Cadaver. To compete for this Medal, students must have attended two sessions at Bishop's, and have obtained 75 per cent of the allotted marks on all subjects. With the exception of one or two years, this medal has been awarded since its endowment, and at times the competition has been very keen and close. I believe the Faculty secured this magnificent Medal, which is of the value of $60.00, through the influence of Dr. Wolfred Nelson, who, as I have already mentioned, was our first registered student, and a member of our first graduating class. In 1882, Dr. David, who had been Dean of the Faculty since the active work of the School began, died, after a lingering illness. The loss which the Faculty sustained by his death was very great, for from its inception he had been its most zealous friend and faithful adviser. To show its appreciation of his work, the Faculty founded the "David" Scholarship, which some years later was changed to the "David" Silver Medal. This is awarded to the student obtaining the highest number of marks in the Primary Examination. The other Prizes in the Faculty are

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"The Chancellor's Prize" (books), to the student who passes the best examination on the Final branches; Prize for the best examination in Histology; Prize to the best Dissector, and best examination in the practical Anatomy course (first year) and a similar Prize for the same (second year). A scholarship, consisting of a reduction of one half the fees, in all theoretical subjects of the Medical course, to the applicant showing the highest aggregate of marks, taken in the Provincial Matriculation examination. A similar scholarship to the graduate in Arts of Bishop's College who shows the highest aggregate number of marks in the Arts course. The vacant position of Dean, and the Professorship of the Theory and Practice of Medicine, was filled in 1882, by my election thereto, and which positions I still occupy. In another year the Faculty will be in the thirtieth year of its existence, and until recently the work has been performed by all as a labour of love, the various members not receiving any money reward for their labour. A surplus there has been over expenses—but this has been used in the purchase of equipment—so that the amcunt so expended now stands at many thousands of dollars. Within the last few years, however, it has been found advisable to obtain special workers, and we now possess two who devote their entire time to College work. These naturally are paid. At this moment the College is as fully equipped for its work as is any College in the Dominion. Our endeavour, and in this I know we are successful, is to give a thoroughly practical training. In one department, Midwifery, whose successful practice has such an important bearing on the success of a general practitioner, we possess advantages certainly not surpassed, if equalled, by any Medical College in Canada—we possess a Women's Hospital which is under the charge of our Professor of Midwifery, where the practice is so extensive as to give our graduates practical charge of as many cases as fall, as a rule, into the hands of the young practitioner during the first four or five years of his professional life. The University has graduated M. D. 222 students. Of these thirty have passed to their rest. Those who survive are in the full pursuit of their life work

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in almost every quarter of the globe. More than the usual success has been obtained by many, due beyond doubt to the eminently practical training they received.

Some have risen to distinction—carving for themselves a name and a professional reputation extending far beyond the cities in which they reside, and reflecting honour on the University which is their Alma Mater. In the special field of Ophthalmology—Dr. Wood, of Chicago, stands pre-eminent among the practitioners in the United States who follow this specialty. This gentleman graduated in 1877, and practiced for at least ten years in Montreal as a general practitioner, filling during that time in Bishop's the chairs of Chemistry and Pathology. Another graduate who occupies a distinguished position in this same field is Dr. H. B. Chandler, of Boston—one of the Surgeons of the Boston Eye and Ear Hospital. I every now and then see evidence of the very excellent work he is doing. In the field of general Medicine I find Dr. Tetreault, of Orange, New Jersey, occupying the position of Medical Health Officer, and a recognized authority on Sanitary matters. In the City of New York I find Dr. Wolfred Nelson holding an enviable position as a Life Insurance Specialist. In Kingston, Jamaica, West Indies, Dr. Bronstorph, who graduated in 1884, I am informed, has risen to the position of one of the leading Surgeons, and has a reputation for Surgical knowledge, and skilful operator, which extends all over the Island. Dr. A. J. Richer, one of our graduates, and on the Faculty Staff, is rapidly coming into notice as an authority on Tuberculous diseases, and is the head of the Sanatorium at St. Agathe. In the far West, at Belt, Montana, I hear of Dr. Vidal, who graduated in 1890, being so pressed with work as to need for several years past, two assistants. Dr. Blackmeer, who graduated in 1884, is Professor of Medical Jurisprudence in the Barnes Medical College, (St. Louis), with a class of over four hundred students. In Montreal I find Dr. Maude Abbott one of our first lady graduates doing excellent work in the Pathological Laboratory of the Royal Victoria Hospital—also Drs. Jack and Foley—who graduated from Bishop's in

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1889 and 1890—forging rapidly to the front as Skin Specialists. Dr. C. R. Wood (M. D. Bishop's 1891)—is in Ujjain, India, doing excellent work as a Medical Missionary. In Literature, my fellow Professor and Bishop's College graduate, Dr. W. H. Drummond, has won a place of great eminence. His book of poems, "The Habitant," is read and admired all over this Continent. These are but a few samples to show that our teaching has not been in vain.

Ever since the Faculty was organized, its members felt that a Dental Department would prove a valuable addition to the University. It was, however, not till about 1895 that the matter took shape and it was then in a measure forced upon it by the action of the Dental Board of this Province. That body had established the Dental College of the Province of Quebec, and sought affiliation with another University. As we had for years given the Medical portion of the Dental Curriculum to many students, we were forced in self defence to seek a change in the Dental Act. In this we failed before the Quebec Legislature, that is we succeeded before the Legislative Assembly—but failed before the Legislative Council. A year later the attempt was made again, and resulted in a compromise.

The Dental College became affiliated to the University of Bishop's College. The result has been excellent to both of the contracting parties. The Dental College has prospered beyond the hope of its most sanguine friends, and the Medical and Dental students fraternize in a way that is calculated to add to the prestige of the two Faculties and the University. Lectures in the Dental Department are delivered in both the English and French languages.

During the twenty-nine years of its existence the Medical Faculty has had many vicissitudes. It has had its periods of despondency and of exultation, but it has, in spite of bitter opposition, never wavered in its determination to continue the struggle till complete success rests upon its Banner. A large measure of this success has already been obtained. To the present members, and those who succeed them, remains the duty of pressing forward on

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the line of their predecessors, Of the original members of the Faculty only Dr. Perrigo and myself remain—before very long we also will be gone. The hope of the school lies in its own graduates, of whom I am proud to say ten are to-day on its teaching staff. It requires Hospital facilities for its clinical teaching. Will not some man or number of men, possessed of the means, come forward in answer to the appeal which is being made for this object ? The Faculty has done, and is doing good work, and deserves recognition.

The establishment of this Faculty of Medicine and Dentistry has exerted a most beneficial effect upon the entire University. The name of Bishop's College is known to-day in every quarter of the Globe, and this is very largely due to its Medical Faculty. If the friends of the University would remember that its Faculty of Medicine is as integral a part of it as the Faculties of Arts and Divinity, it would inspire additional enthusiasm among its workers. I hope the future—the near future, will show evidence of it.

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# Selected Article.

## FOUR CASES OF DIABETES MELLITUS OF APPARENT BACTERIAL ORIGIN, AND THEIR SUCCESSFUL TREATMENT.

By J. P. SHERIDAN, M. D., of New York City.

In the latter part of 1898 a writer in the *Medical Record* related his experience with bichloride of mercury in the treatment of diabetes mellitus, and advanced the novel theory of the bacterial origin of this affection.

At the time of publication of the article in question I had some diabetics under treatment. As a moderately rigid antidiabetic diet and the time-honored remedies did not check the glycosuria in my patients, I adopted the newly proffered theory and eagerly prescribed the advocated chemical.

To-day, after a year's trial of germicidal remedies in diabetes, I have become a firm believer in the bacterial origin of diabetes. It is true, the bichloride of mercury did

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not prove a success in my hands, but this only tends to demonstrate the existence of a peculiar diabetic toxine, which has to combated by other means. This toxine, in my opinion, is particulary apt to attack the nervous matter, which in turn gives rise to the well-known disturbance of metabolism in diabetes—namely, preventing the deposition of glycogen in the liver and muscles and causing its discharge by the kidneys in the form of grape sugar. The irritation of the vaso-motor centers, to which may be attributed all the symptoms of diabetes, seems to be caused by this toxine. It is plainly the physcian'y duty to eliminate the toxic influences, for he thereby relieves the irritation of the nervous centers. However, he must be most careful in the selection of the proper remedy and in the administration of its indicated dose. The failures in diabetic therapy have to be ascribed either to a wrong medicine or its improper administration, or to both. The ideal autidiabetic drug should not only exert distinct germicidal and antiseptic powers, but should be a powerful alterative. At the same time, the system should not become weakened and emaciated by its prolonged administration. On the contrary, the ideal diabetic remedy should afford great tonic properties.

Bichloride of mercury and auri et sodii chloridum, which latter is so much lauded of late by a Chicago physician, possess some of these desiderata, bur neither proved of any success in my hands in the treatment of diabetes mellitus. This non-success is due to three factors :

(*a*) The specific toxine of diabetes is affected only by a specific antiseptic.

(*b*) Bichloride of mercury or auri et sodii chloridum, when pushed to their physiological tolerance, do not effect the decline of the glycosuria.

(*c*) Bichloride of mercury, as well as chloride of gold and sodium, when administered for any length of time and in larger doses, reduce the oxidizing power of the red blood cells, thereby weakening the system and producing rapid emaciation.

The remedy answering all the demands for an ideal antidiabetic I find in a combination of bromide of gold with bromide of arsenic, called by its makers " arsenauro." This preparation undoubtedly exerts a specific influence upon the bacteria and the toxine of diabetes mellitus, which is elucidated by the following four cases :

CASE I.—Mr. C. L., aged fifty, American, clerk, consulted me on June 8, 1898. Family history was negative.

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Patient complained of polyuria, the existence of which dated back about three months. The frequency in urination he thought to be due to a stricture, the possible result of a neglected gonorrhœa. Patient had a moderate appetite, felt quite thirsty at times, and had lost some weight. The urine (which was voided to the amount of about seven pints daily), on June 10, 1898, showed a specific gravity of 1038, and contained 7.1 per cent. of sugar, as ascertained by means of Stern's urinoglucosometer. A restricted diet and the administration of codeine caused only a moderate improvement of the symptoms. Bichloride of murcury. which was given for the last three weeks of December, 1898, in the doses recommended, not only produced no beneficial influence whatsoever upon the diabetic condition, but actually aggravated the condition of the patient. Early in July, 1898, my attention was drawn to the chloride of gold and sodium which was handed to the patient in tablet form and administered first in doses of a fiftieth of a grain. The dose was gradually increased to a twentieth of a grain. After five weeks' trial of this drug it had to be abandoned, as the condition of the patient had become alarming in the meantime.

At about this period I ran across an article in the *New York Medical Journal* regarding the use of arsenauro in diabetes, and determined to test this product, having previously used it with satisfactory results in malarial toxæmia.

On February 7, 1899, eight drops of arsenauro were given in half a glass of water three times daily. The restricted diet was ordered to be continued. Patient reported to me in one week. The glycosuria and polyuria were greatly diminished. The feeling of thirst was not experienced any longer, and he expressed himself as feeling perfectly well. The dose of arsenauro was gradually increased until he reached his full limit of toleration, which supervened at fifty drops. The quantity was lessened to forty-five drops, and continued in this dose for sixteen weeks. After this period I examined the urine, which revealed a specific gravity of 1.020 and was absolutely free of sugar. Patient was discharged as cured, with the instruction to continue the arsenauro for at least six months.

CASE 2.—M. H., a woman, aged thirty-four, American, unmarried, came to consult me September 11, 1898. In July previous, during the hot spell, she perspired greatly and suffered from excessive thirst. Her weight, which normally was a hundred and sixty-five pounds, had diminished to a

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hundred and thirty-five pounds. Frequent micturition was distressing her greatly. Appetite was voracious for some time,and her strength graduelly declined. When first seen by me the daily quantity of her urine amounted to eight pints. Specific gravity, 1.046; sugar, 7,538 grains a day. She complained of incessant thirst, inordinate appetite, pain in back, and extreme feebleness. She was put on a restricted diet on September 20th, but no medication given her. Patient improved somewhat, but not sufficiently. In December, 1898, bichloride of mercury was given and the same diet continued, without effecting any noticeable change in the patient's condition. In February, 1899. she was put on arsenauro, and the same diet still continued. The medicine was started in eight-drop doses three times daily, to be taken in a glassful of Vichy water. Ten days after, great improvement had taken place. The urine became reduced to forty-nine ounces, specific gravity 1.028, and the sugar output to two hundred and ten grains for the twenty-four hours. After this the dose of arsenauro was gradually increased until the patient reached her full physiological limit; this took place at forty-drop doses—that is, after the administration of two drachms a day. Patient was instructed to occasionally discontinue the administration of the remedy for twenty-four hours, and then to start again on thirty-five drops.

This latter dose was taken for some months, with the result of rendering the urine entirely free of sugar, She was advised to continue with the medicine for at least six months longer. I examined her urine of late and found it absolutely normal and free of sugar.

CASE 3.—H. E. B., a man, aged thirty-seven, American, railroad conductor, consulted me in March, 1899, on account of an irritable bladder. Patient was compelled to urinate quite frequently during the day as well as during the night. His other symptoms left no doubt as to his real affection—diabetes mellitus. The disease, so far as I could ascertain, dated back for about a year, and seemed to be devoid of further complications. The quantity of urine voided varied from twelve to fifteen pints a day, with an average specific gravity of 1.042. Sugar average four thousand grains for the twenty-four hours. The treatment consisted in restriction of diet and the administration of arsenauro, ten drops of which were ordered to be taken in half a goblet of water three times a day. This dose was gradually increased until patient took sixty drops three times daily. When this quantity, three drachms, was taken every day, the patient's lids began to puff and his bowels became loose and caused

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griping. The medicine was discontinued for twenty-four hours, but again ordered to be taken in fifty-five drop doses. Patient had taken the fifty-five-drop doses for eight weeks, when I again examined his urine, which contained only a trace of sugar. One month later he was perfectly well, and all vesical irritation had disappeared—in fact, I pronounced him well. I advised patient to report to me from time to time, but to continue tke arsenauro for at last six months.

CASE 4.—B. R., aged forty-seven, a woman, unmarried, American, milliner, thin and emaciated, able to attend to her business, consulted me April 22, 1899. Patient complained of great weakness, which had gradually increased for several months. She had excessive thirst and had voided a greatly increased quantity of urine, but her appetite was moderate. Her skin was dry, and she complained of intense pains in the calves of her legs, especially in the morning. There was distressing pruritus vulvæ present. The specimen of urine sent to me for examination presented a specific gravity of 1.045, and contained 8.1 per cent. of sugar I restricted the patient's diet as to starches and sugar, and placed her at once on ten-drop doses of arsenauro, to be taken in a half tumblerful of water three times daily. After one week the dose of arsenauro was increased three drops every day until she reached its toleration. Physiological saturation was obtained when forty-five drops were taken three times a day. The administration of the remedy was then stopped (as I am in the habit of doing) for twenty-four hours, after the lapse of which it was again ordered to be taken in forty-drop doses. This dose was kept up for six weeks. On July 3d she had gained seven pounds in weight; urinallysis demonstrated entire absence of sugar; the pruritus had entirely disappeared, and there were no evidences whatsœver of symptoms pertaining to diabetes mellitus. Patient was advised to continue the medication for at least another six months.

The four cases which so readily yielded to this antioxic treatment were apparently of bacterial origin. Arsenauro, by saturating the system arrested bacterial activity, or killd the germs, or neutralized their toxines. However, only by saturation with the proper medicine—and, by the way, arsenauro is the only powerful alterative neutralizer which which can be pushed to an almost incredible dose without doing bodily harm—can such results as are recorded in the foregoing be obtained.—*Interstate Medical Journal.*

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# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

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### RICKETS—THE TREATMENT OF.

For patients in the first few years of life, from 1½ to 5 years, my plan of campaign is practically the same for all. For those with heavy bodies and heads, protuberant bellies, head sweats, and commencing or acquired bow-legs or knock-knees, the food supply is carefully attended to, the digestive functions restored as soon as possible, starchy food being limited, fats being recommended, especially bacon fat and dripping, which I believe has for these cases a high nutritive value. For very young children especially the addition of some cream to the dietary is most valuable. Condensed milk, if it be taken, should be replaced by cow's milk boiled, and a weak gravy soup or broth will often help to stop the rickety tendency. For marasmic patients nothing acts so well as a daily rubbing under each axilla of cod liver oil. For all these rachitic patients, then, varying the dose slightly according to age, I prescribed cod liver oil and syrup of the phosphates of iron. In very hot weather I let the children leave off the oil, but the mixture generally is very well taken, and the results are most satisfactory. In cases with any tuberculous or syphilitic history, the syrup of the iodide of iron should be substituted for that of the phosphates. Next as to the treatment of the rickety deformities, especially of the leg bones. In the case of patients under the age of 4 years, even with very marked bowed and bent tibiæ, and some degree of knock-knee, I can assure the parents with great confidence that after nine months' to fifteen months' treatment these deformities will be very greatly improved or altogether remedied. I am prepared to leave any question of operation to a later age—say that of 5 or 6 years. By that time we can see whether ordinary treatment has been able to effect anything, the bones have got harder, and there is less risk of producing the calamitous condition of pseudarthrosis. These children's legs should be put up in

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splints, preferably outside ones, which may purposely be made three or four inches too long. The splints should be taken off once every month or three weeks in the winter and once a fortnight in the summer. I do not deny that a rickety child's legs occasionally becomes much straighter with no treatment whatever. Still I feel sure that the great mass of these rickety children are far better when off their feet—for this reason, that the deformity of the pelvis is so much less apt to 'occur, as little or no pressure is acting upwards through the acetabula while the child is lying down or even sitting up.—From Dr. E. Mansel Sympson's article in *Pediatrics*, October 15,·1899.

## TYPHOID FEVER, DIET IN.

Dr. E. J. Abbott (*Northwestern Lancet*, August 15, 1899) says that it has been his practice for years to allow his typhoid patients what is termed "soft diet" instead of milk diet, namely, a diet consisting of milk if it is agreeable, buttermilk, all kinds of soups and broths, eggs, raw or soft, or the yolk, if they like, of hard-boiled eggs. By hard-boiled eggs he does not mean an egg that is boiled four or five minutes, just sufficient to coagulate the albumen, but an egg that is cooked from one-half to three-quarters of an hour. The yolk of an egg in this condition is easily digested and is nutritious. He also permits custards, rice, farina, junket, tea, coffee, chocolate, cocoa, ice cream, and particularly milk and cream-toast and all foods of that class. The writer says he has never yet had cause to regret feeding his patients in this way, and is convinced that this diet leaves less waste of indigestible material as a possible irritant to the ulcerated surface than does an exclusive milk diet. The writer also advises the lengthening out of the intervals of feeding from two to three or four hours, perhaps even longer, and thinks that by doing this his patients relish their food more than before, and that they will digest it better and will recover from the fever stronger and in better condition than they would otherwise.—*Medical Age*, October 10, 1899.

## CONVULSIONS IN CHILDREN.

Drs. Gossage and Coutts make the following remarks in their paper: All that is necessary during an actual attack of convulsions in most cases is to loosen the clothing about the neck, chest and abdomen, and to lay the child on its

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back with the head slightly raised until it recovers consciousness from the fit and the subsequent drowsiness. The placing of the child in a hot bath, as is such a common practice, probably does no harm, and if the child be in feeble health it may be advantageous to use a mustard bath, which has decided stimulating properties. Cases, however, where the unconsciousness is unduly profound and prolonged, and especially if with this further fits are associated, require more active measures. Chloroform inhalation is the most efficacious of these, and profound unconsciousness is no bar to its employment, recovery from the anæsthetic being usually accompanied by regain of consciousness. The inhalation of chloroform may be replaced, or in severe cases followed by the rectal injection of chloral in doses of 3 gr. to an infant of six months, to which 2 to 3 gr. of potassium bromide can be added if desired. Some authorities have recommended the inhalation of nitrite of amyl in 1-minim doses, and Eustace Smith praises the hypodermic injection of morphine in doses of $\frac{1}{24}$ gr. to an infant of six months, and says that it can be repeated, if necessary, in the course of half an hour. Any local irritation which may be regarded as an exciting cause of the fit calls for appropriate treatment.—*British Medical Journal*, August 19, 1899.

## EPILEPSY—BROMIDE OF CAMPHOR IN.

Hasle (*Thèse de Paris*, 1899), after carefully selecting a number of cases of epilepsy from the abundant material at Bicêtre, obtained the following very constant results: (1) As regards epilepsy proper (*haut mal*), the action of bromide of camphor was doubtful, and was less effectual than the mixed bromides of potassium and sodium and ammonium. (2) In attacks of *petit mal*, and in all cases of epileptic vertigo, however, its effect was incontestable; it at first diminished the frequency of the vertiginous attack, and finally made them disappear altogether. The condition to be observed in prescribing was to begin with moderate doses, made gradually progressive, and lasting for a sufficient time. Owing to its disagreeable odour it is best taken in capsules of 20 centigrammes, or dragees of 10 centigrammes, beginning with two capsules per diem, and augmenting by two capsules the second week, etc., till eight capsules per diem are taken, then as gradually diminishing the dose till two capsules per diem are reached and maintained for some time.—From abstract in *Epitome, British Medical Journal*, August, 5, 1899.

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## DIARRHŒA, CHRONIC INFANTILE.

Irrigation of the large bowel, carefully and thoroughly carried out each day with a fountain syringe and No. 12 catheter (not too flexible) is of decided benefit. A gallon of fluid should be employed for each irrigation, the liquid being at 98° to 100° F. Saline solution, boric acid solution, or nitrate of silver, 7½ grains to the gallon, have all in my hands been most useful. The child lies with the hips elevated; the catheter, well oiled, is allowed to gently pass six or eight inches up the bowel, the liquid being allowed to flow gently during its introduction, and the reservoir not raised more than three feet above the child's body.—From Dr. A. Jacobi's paper in *The Therapeutic Gazette*, August 15, 1899.

## THE TREATMENT OF SCARLET FEVER.

This subject was discussed at some length in the section of Diseases of Children at the annual meeting of the American Medical Association (reported in the Philadelphia *Medical Journal*, July 1), and Dr. R. A. Birdwood, Medical Superintendent of the Park Hospital, Lewisham, has stated his experience in the *Hospital*, April 15, 1899. In an ordinary mild uncomplicated attack of scarlet-fever Birdwood keeps the child in bed for three weeks on a low diet with stewed fruit till three days after the temperature has fallen to normal. The bowels are opened daily, and the urine tested for albumin on alternate days. The reason for so long a stay in bed is that if nephritis supervenes it usually does so about the end of the third week, and the maintenance of the regular action of the bowels seems to have a marked and beneficial effect in preventing œdematous swellings of the legs. They are also detained in bed whilst albuminuria or dilated heart persists, and when in bed are blanket-bathed daily. It is not prudent to use the bath during this time, as faintness or a bad colour comes on occasionally. During convalescence, if all goes well, a warm soap and water bath is given three times weekly. As a rule, this is sufficient treatment for desquamation. A. Gilbert recommends anointing the skin with lard, vaseline or lanolin. If desquamation continues, a weak acid solution, such as an ounce of dilute acetic acid to half a pint of water, applied to the soles or palms on lint for a quarter of an hour, or else rubbing with glycerine and borax, does much to remove adherent epithelium. Desquamation may go on for three or

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four months, or even longer, and it is quite common for it to come on twice and sometimes three times.

*High Temperature.*—B. Gilbert objects to the use of coal-tar antipyretics, and to the full bath unless the fever is very high and there is very active delirium. The nervous excitement can best be allayed by chloral hydrate. Slagle and Ewing agree in objecting to antipyretic drugs, but advocate the free use of cold water for drinks, enemas and packs. By drinking water freely they contend that the toxins are eliminated. Quayle prescribes lithia water and Ewing prescribes potassium acetate in addition. Garrison has used acetanilid for eight years, and finds it useful; it promotes a feeling of well-being, and if combined with soda bicarbonate does not diminish the renal secretion. Garrison does not hesitate to employ antipyrin if the pulse denotes high arterial tension, and has given it to young infants in doses of a quarter of a grain. Birdwood finds that the high temperature of scarlet fever is well controlled by sponging with tepid water, and the patient generally feels better after it is done. It is good practice to sponge whenever the four-hourly temperature exceeds 39° C. Hyperpyrexia of scarlet fever is not controlled by baths or drugs; the former may be frequeutly repeated, but the temperature rises again, and the patient becomes rapidly worse. Now and again a patient recovers after a temperature of 41° C., and this encourages one to keep on with tepid sponging. An undoubtedly good effect is sometimes observed in the reduction of temperature on removal of blankets, and leaving the patient covered with a sheet only. If either sponging or removal of blankets induces shivering or a feeling of coldness, or actual coldness of the extremities, it should be discontinued, and warm water bottles should be used. A thirsty fever patient should be given plenty of drink, and it is well to remember that there is sometimes a repugnance to milk. Water relieves thirst best, and should be given. Grape or orange juice is generally liked, and does good. Barley water is a suitable drink.

*Sore Throat.*—A chlorine gargle is used at the Park Hospital (chlorate of potash, ʒiss.; hydrochloric acid, ʒvj., with five pints of water added after the evolution of the gas) when an acid preparation is desired, or Liq. sodæ chlorinatæ 1 in 15 of water when an alkaline. Equal parts of either of these chlorine solutions and warm water are mixed just before use. If the patient is not old enough to gargle, a ball syringe with a long nozzle attached is used for flushing

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out the fauces. Two 4 oz. syringefuls are enough. Should the patient resist the attempt to pass the nozzle between the teeth, there is no occasion to use force to do so. The fauces can be well washed by passing the nozzle between the cheek and the teeth, so that its point goes just beyond the last molar tooth. This should be done first on one side, then on the other. The patient should be held with the face downwards. The practice of gargling the throat is far better than swabbing, for the tissues are often soft enough to be damaged by the latter proceeding.

*Nose and Ear Discharges.*—A solution of boric acid (ʒii. to 5 pints) is used by Birdwood; before use it is mixed with an equal quantity of warm water.

*Nephritis.*—Birdwood usually orders loin poultices or fomentations. In some instances the drawing of a few ounces of blood has been followed by a flow of urine; in others, no such result has ensued. Seidlitz powders or compound liquorice powder should be given, not calomel. Solomon prescribes cascara and sodium phosphate, and also a decoction of scoparius (ʒi. to Oi) to relieve the kidney congestion.

*Joint and Muscle Pains.*—Solomon has found acetanilid useful in relieving the severe headache and pains in joints, but where muscular pain was complained of he gave phenacetin instead. Birdwood employs salicylate of soda.—Dr. Francis J. Allan's abstract in *Treatment*, September 14, 1899

## HABITUAL CONSTIPATION.

The treatment detailed is intended for habitual constipation. For the immediate unloading of the bowel one of the simplest and least harmful methods is the giving of one or more enemata of warm water, containing salt in the proportiou of a teaspoonful to a pint. Soapy water may be used instead, if something stronger is needed. The amount to be injected varies with the age. For youug babies, one or two ounces in sufficient, and for those of two years, two or three times this amount. Either the hard-rubber syringe or the infant's syringe may be used. A useful injection consists of half a teaspoonful of glycerin in full strength. This is best given from a small hard-rubber syringe holding not more than half an ounce. The opening in the nozzle should be larger than ordinary, as the glycerin does not flow readily. If the mass in the bowel is large and hard, an injection of warm sweet-oil, retained some hours if possible, is better than any-

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thing else. It should be followed by an enema of soapy water. In some cases it is necessary to insert the finger or a small spoon-handle into the bowel and break up the masses carefully.

Glycerin suppositories—glycerin and soap—of a size for children are often exceilent for opening the bowel. Gluten suppositories are also serviceable in many instances. A more economical plan is to employ little home made suppositories of castile soap, or, in place of these, a soap stick which can also be made at home, and which has the value of lasting for repeated usings. It consits of a smooth conical stick of firm castile soap two or more inches long, half an inch thick at the base, and tapering toward the other end to the thinness of about one-quarter of an inch. It should be greased with vaselin before using, inserted part way into the bowel and held there until a tendency to an evacuation shows itself.

If none of the methods described is effectual, laxative drugs must be employed. Their use, however, ought to be deferred as long as possible, and is much better left to a physician. Probably the best and least harmful of drugs is cascara in some form. There is made a cascara cordial which has a pleasant taste and is very effectual. Another very useful preparation is the syrup of senna, which is easily taken by children, as its taste is agreeable. Little sugar coated pills, each containing one-tenth grain or less of aloin are sometimes of service, one being given daily to a child of two years. A small quantity of manna, about five grains, can be given to a baby of six months once a day or oftener, dissolved in the milk, as its taste is sweet, or ten grains of phosphate of soda may be used in a similar manner, Magnesia or spiced syrup of rhubarb answers very well, but only for occasional use.—*Jour. A. M. A.*

## CARE OF THE MOUTH.

Perhaps no part of the body is so often neglected as the mouth; especially is this noticeable in the case of children. A mother who will religiously bathe her ehild and keep its body sweet and clean will often fail to cleans its mouth. A new-born infant should have its mouth washed after each feeding; a soft cloth wet in a weak solution of boracic acid should be used for this purpose. If this were always done we would rarely find a case of infantile sore mouth.

After the teeth come and the mouth is large enough, a small, soft brush should be used; the teeth and mouth should be thoroughly cleaned at least twice daily.

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In illness where sordes and mucus accumulate rapidly, and where the tongue and lips are parched and stiff, attention is needed every hour; the mouth should be kept moist and the same treatment carried out through the night as during the day. Boracic acid solution, listerine, lemon juice, glycerine and distilled water are all refreshing, and soften the tissues; where the lips are chapped or fissures appear, a lubricant of cold cream or sterilized vaseline should he applied. Where the gums are spongy or soft; and bleed readily, a few drops of tincture of myrrh added to pure water will help to harden them. Small squares of old linen or soft gauze should be used instead of a brush where one is ill or week. These should be immediately burned after use.

Every part of the mouth should be cleansed; behind the wisdom teeth, the roof of the mouth and under the tongue; lemon juce and water will remove the fur from a thickly coated tongue. Where the teeth are sensitive the water used should be slightly warm.—*South Cal. Practitioner.*

## ATROPINE IN DELIRIUM TREMENS.

Touvine (*Archives Medicales Belgiques*) administers atropine to his alcoholic patients in one sixtieth grain doses hypodermatically. The result is to quiet them, and to put them to sleep in a few minutes. It is believed that the prompt action of the atropine is due to its stimulating effects on certain centers of the brain, thus inducing the quiet and sleep.—*American Practitioner and News.*

## THE TREATMENT OF HICCOUGH.

M. J. Noir records the case of a girl, six years and a half of age, who suffered from persistent attacks of hiccough. M. Noir, on seeing her in one access, which had continued for six hours and a half, drew out the tongue and held it protruded for the space of a minute and a half, which calmed the spasms as if by enchantment. They did not reappear. This procedure is not altogether new, but is not, we think, sufficiently appreciated.—*Progres Medical.*

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# SURGERY.

IN CHARGE OF

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## AN IMPROVED METHOD OF ABDOMINAL INCISION.

George R. Fowler, in the *Medical News* of March 3, 1900, says that two cardinal points must be borne in mind in making the incision through the abdominal wall. It should be so made that all parts involved in the intended operation are readily within reach. Weakening of the wall of the abdomen should be avoided by carrying the incision, whenever practicable, in the direction of the fibers so as to avoid cross-sectioning the muscular and fibrous structures. The incision in all cases of appendicitis should be so planned as to admit of removal of the appendix. In his experience access to the base of this organ is secured in the largest number of cases through an incision so planned that its center strikes a point corresponding to the intersection of a line extending from one anterior superior spinous process of the ilium to the other, with a vertical line drawn half-way between the median line and the right anterior superior spine. This differs from Clado's point.

The skin incision commences at the upper rounded prominence of the anterior superior spinous process of the ilium, is carried almost horizontally to the outer edge of the rectus abdominis muscle, from which point it is curved downward and extended parallel with the edge of the rectus for a distance of two and a half inches, or more, as required by the exigencies of the case. The skin, fat and fascia are divided, and the triangular-shaped flap with rounded corner dissected and reflected downward and outward, exposing the aponeurosis of the external oblique.

A retractor is applied at the lower angle of the wound and another at the middle of the horizontal incision. Traction upon these in the direction of the course taken by the

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external oblique exposes the latter for a distance of three or more inches, if necessary. This structure is divided in the direction of its fibers to the extent of its exposed portion, two more retractors applied, and the sheath of the rectus exposed and likewise opened. The rectus muscle and the underlying deep epigastric artery and veins are now retracted toward the median line, the outer edge of the incised aponeurosis being retracted in the opposite direction. A space of four inches in its transverse diameter is thus exposed.

With the rectus well displaced toward the median line, care being taken to retract the deep epigastric artery and veins as well, and the outer edge of the incised external oblique aponeurosis retracted in an outward direction, the following parts are exposed: In the outer two-thirds of the space between the retractors is to be seen the muscular portion of the internal oblique, this terminating in the aponeurotic portion of this muscle at the point where the aponeurosis divides to enclose the rectus (the linea semilunaris). The inner third includes that portion of the exposed space left by the inward displacement of the rectus muscle, and is occupied by the posterior lamella of the sheath of the latter. In this space the transverse incision is to be made. For this operation the remaining structures of the abdominal wall may be considered as one layer, and the transverse incision carried directly through these in the direction of the fibers of the internal oblique and transversalis into the peritoneal cavity. The incision is commenced at the inner end of the space beneath the rectus muscle and access gained to the cavity of the peritoneum at this point first; after which, with the finger as a guide, the section is completed. Retraction of the edges of the transverse incision will be found to give ready access to the region of the cæcum.

At the completion of the operation the parts are to be replaced and sutured. The transverse incision is closed by running a catgut suture including all of its layers. In closing the incision in the external oblique aponeurosis, care must be taken to include in the suture the incised edge of the sheath of the rectus muscle. The muscular structure itself should not be included in the suture, since the interposition of this between the incised edges of the sheath which may follow the attempts to include the muscle will prevent the prompt union of the aponeurosis.

In view of the supreme importance of securing immediate firm and permanent union of the aponeurosis of the external oblique, it is best to employ kangaroo tendon for the

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suture material in the case of this structure at least. Finally, the skin wound is to be close. This may be done by the ordinary interrupted suture, although this, as all skin incisions, is best closed by the subcuticular suture.—*Medicine*.

## A NEW METHOD OF DILATING A STRICTURE OF THE ESOPHAGUS.

J. S. Pyle, in the *Philadelphia Medical Journal* of Feb. 3, 1900, describes a rare case of stricture of the esophagus following typhoid fever. In Keen's work on the surgical complications of typhoid two cases are mentioned, and Osler has described a case. While this complication is rare, the real interest of Pyle's communication relates to his novel method of treating the stricture. The difficulty of swallowing precluded the taking of solid food, and as time progressed the ingestion of liquids was attended with great difficulty. The stricture was situated at the esophageal opening of the diaphragm, and it could not be enlarged by the use of probangs or dilators. He was able to pass a small bougie, and later devised a small instrument somewhat after the plan of a Barnes dilator. Between two layers of fine rubber tissue a silk bag is placed, the whole being, when dilated to the full extent of the silk, about the size of the little finger. This was mounted upon a small rubber tube and carried with the aid of a small wire through the stricture. With a suitable pump the apparatus was filled with water and the stricture successfully dilated. This was accomplished with very little discomfort to the patient and the complete relief of the stricture.—*Medicine*.

## THE TREATMENT OF EPIDIDYMITIS.

H. M. Christian, in the *Therapeutic Gazette* of March 15, 1900, says that for the last few months applications of guaiacol have been adopted as a routine practice at the University and Polyclinic Hospital of Philadelphia. Since this form of treatment was instituted, about sixty cases of epididymitis have been treated. These were all acute walking cases. In all but six great relief from pain followed during the course of the first twenty-four hours after application. All were able to keep on their feet through the whole of the attack, with little discomfort. The application of the drug was followed in all cases by a smarting and tingling sensation in the skin, lasting for about an hour.

In all cases the testicle was first gently massaged with

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a 20-per cent guaiacol ointment made up with lanolin. Some of the ointment was then spread upon lint and applied to the part, the whole being enveloped in a layer of absorbent cotton, over which was applied a snugly fitting laced suspensory bandage. The dressing was reapplied every second day. At the end of about six days after the inflammation and pain had ceased, the guaiacol was substituted by an ointment composed of

℞ Unguentum hydrarg.....
Unguentum belladonnæ.....
Ichthyol.....
Lanolin.....ää ʒ ij.

It was found that this application produced a prompt lessening of the inflammation and a rapid return to the normal size.—*Medicine.*

## TREATMENT OF AORTIC ANEURISM.

Moritz Schmidt, in the *Medical Chronicle* for March, 1900, discusses the early diagnosis and treatment of aortic aneurism. During the past eleven years he has seen fifty-four cases. Of these thirty-eight had paralysis of the left recurrent laryngeal nerve. Tracheal tugging was present in nineteen of thirty-one cases. He regards this as one of the most decisive symptoms in the early stage of the disease. A less definite indication is a murmur. This may be due to tumors of the mediastinum and is frequently absent in aneurism. He prefers iodide of potassium and strict rest in the treatment of aneurism. In addition Tufnell's limited diet is employed, which includes a marked reduction in the amount of fluid allowed the patient. A lessening of the fluid to 1200 grammes is not difficult, but a further reduction is often followed by distress and must be gradually employed. In one of his cured cases the amount of fluid was reduced to 340 grammes; this was followed by a nervous condition which compelled the raising of the amount of fluid to between 500 and 600 grammes. His paper is illustrated with radiographs. He comes to the conclusion that the treatment of aortic aneurism should be undertaken early, and the condition should be regarded as a curable one, and a rigid system of dietetics and medicinal measures instituted. If these are undertaken with confidence, he thinks that the results in the treatmen of this condition will be greatly improved.—*Medicine.*

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## SUPRARENAL EXTRACT IN THE URETHRA.

In a discussion before the New York County Medical Society (*Medical News*, March 24, 1900), J. A. Moore stated that he had used suprarenal extract more than two hundred times in the urethra. He has found instrumentation possible without bleeding, and with the production of very little irritation if the extract has been previously used. This should consist of a 10-per-cent infiltrate solution, which may be injected without causing the slightest irritation, and is followed by a decrease in the irritability in the pathogenic structures. When a structure is to be stretched, it lessens the congestion, increases the caliber of the urethra, and prevents bleeding. The effect of suprarenal extract is evanescent, and if two or more sounds are to be passed it is necessary to employ a second injection. There is no danger of constitutional symptoms, nor has the extract any action on the urethra. In six meatotomies he used a 12-per-cent solution injection hypodermically and had very little bleeding after the operation. In gonorrhea the injection of suprarenal extract in two cases gave complete relief from the smarting, and there was no pain in urination during the acute stage.—*Medicine.*

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To avoid the harmful effects of the X-ray from either a static machine or a coil as an exciter one should never have the tube near the patient; it should be two or three feet feet away when using the fluorescent screen, and should be three feet or more from the plate when taking x-ray photographs. Between the patient and the Crookes tube there should always be placed a thin screen of aluminum, which should be grounded by connecting it to the gas-pipe with a proper wire.—F. H. WILLIAMS.—*N. Y. Med Rec.*

## SEQUELÆ TO HERNIOTOMY.

(1) The wound may not unite by first intention, and if the sac has been very adherent the disturbance of the cellular tissue may cause some sloughing. In such cases the wound should be reopened and stuffed with iodoform gauze. (2) Diffuse general peritonitis may set in; this is known by the persistence of the vomiting, the continuance of the pain, distention, and tenderness of the abdomen, with elevation of temperature. This may be due to leakage from a perforation, to a gangrenous condition of the gut, or to the introduction of septic matter from without at the time of operation, as in

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any other abdominal section. Immediate laparotomy should be done. (3) The reduced gut, which has been returned as suspicious, may become gangrenous and obstruction of the bowel may still continue. If this condition be suspected, the abdomen should be opened and the gangrenous bowel sought for, and either resected or incised, and kept outside the abdomen with the object of forming an artificial anus. (4) The bowel may not be gangrenous, yet be so injured that it may not be able to resume its proper functions, and the patient may die in consequence if not relieved by a laparotomy. (5) The bowel may be temporarily paralyzed by local inflammation so as not to be able immediately to resume its functions, though after some days it may recover completely its normal condition. In such cases there is obstinate constipation, without vomiting or other signs of peritonitis. (6) Cases of acute mania have followed the operation for strangulated hernia, some of which have proved fatal.—SHEPHERD, "American Text-Book of Surgery."—*N. Y. Med. Rec.*

## SURGICAL HINTS.

NEVER USE MORPHINE BEFORE ANÆSTHESIA in patients who are in a state of stupor or traumatic shock. In these the drug has a distinct tendency to increase these conditions.—NEVER HAVE ANY MORE ASSISTANTS at an operation than are absolutely necessary. They are apt to get into each other's way, and the more people help you, the greater the difficulty of securing asepsis.—EXCEPTING IN EMERGENCY CASES, every patient about to be operated on is entitled to as careful an examination as if he were applying for life insurance, and to treatment before the operation for any complicating condition.—THERE ARE CERTAIN PATIENTS in whom it is very desirable that they shall make no violent movements while they are being anæsthetized, as for instance in certain fractures. In these cases a full dose of morphine an hour before the anæsthesia will contribute a great deal to secure a quiet etherization.—WHEN USING COCAINE hypodermically, it is seldom necessary to use a solution stronger than one per cent., and then always have the patient in a recumbent position. The danger of cocaine lies in the possibility of syncope from failure of the heart's action, and lying down is the best preventive.—WHEN OPERATING, never put too many instruments in one tray, as it becomes more difficult to find just what you want. It is best to have several small trays, and to put the cutting

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instruments in one, the artery forceps in another, and the special instruments required in the particular operation you are doing in a third.—DURING THE REMOVAL OF TUMORS having many attachments, it is a good principle to free first all the points that are easily detached, and to pediculate the tumor, as it were, where it is most difficult to free it. This will usually result in the largest vessels being included in the pedicle, so that with your ligature or clamp you may safely secure the most dangerous region, and cut above it without danger.—IN OLD OVARIAN LESIONS, it is often a fact that the patients show a decided insufficiency in the secretion of urea. It is well to subject such patients to preliminary treatment for this condition, for two reasons: The first is that if the proper treatment increases the excretion of urea the patient will have a better chance of recovering from the operation, and the second is that if the patient's urine shows no improvement, the prognosis is rendered more serious, and forewarned is forearmed.—*International Journal of Surgery, N. Y. Med. Record.*

## CURLED HORSEHAIR IN PLACE OF A SCRUBBING-BRUSH.

W. S. Forbes, in the *Penn. Med. Jour.*, says that ordinary curled hair forms one of the best mechanical devices for cleansing the skin that has yet been discovered. In its preparation about three drachms of curled hair is employed, and this is easily shaped by the hands into a loose pad about the size of the hand. When desired, the flattened mass may be held together by stitching with sterilized silk, catgut or other aseptic material, but this is opitional. When once fashioned, it will hold its shape without change. It can not cut or tear the skin, and it is easily cleansed with boiling water before and after each surgical operation. A solution of bichloride of mercury, one to one hundred, and steam to 100° do not act upon it. It may be kept in alcohol after being sterilized, and is thus always ready for use. It is cheap and efficient, and is far superior to the scrubbing-brush of tainted memory.

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# OBSTETRICS.

IN CHARGE OF

H. L. REDDY, M.D., L. R. C. P., London,

Professor of Obstetrics, University of Bishop's College; Physician Accoucheur Women's Hospital; Physician to the Western Hospital.

## TREATMENT OF ACUTE PUERPERAL SEPSIS.

H. N. Vineberg brings out the following points in a paper on puerperal sepsis.

1. Puerperal sepsis is wound fever or wound infection, and wound infection in the female genital canal, as elsewhere, calls for surgical measures, such as free drainage, irrigation, and the removal with a sharp instrument of any débris or exudate that may form on the surface of the wound. These means failing to accomplish the desired result, perform ablation of the diseased organ.

2. In a given case of puerperal sepsis a thorough search is to be made of the whole of the genital canal, in order to determine the site of the original infection.

3. If this is situated in the uterus, curettage, drainage, and irrigation are to be employed. In 95 per cent. of the cases of puerperal sepsis nowadays met with, this plan of procedure will be all that is necessary to bring about a cure.

4. In the remaining 5 per cent, roughly speaking, these measures fail to arrest the infection. An exploratory laparatomy is then indicated, the further course to be guided by the pathological lesions found. In most cases total hysterectomy will be required.

5. When large collections of pus form and are so situated that they can be readily reached either with a vaginal incision or with one above either of Poupart's ligaments, no time should be lost in resorting to surgical relief. When, however, they are not so favorably situated, judicious delay is advisable, with the hope that ultimately the pus may be evacuated without the risk of soiling the general peritoneum; —*Jour. Obstet.*

## ANTISTREPTOCOCCUS SERUM IN PUERPERAL SEPTICEMIA.

H. W. Webber reports a case in which a favourable result was obtained from one injection of antistreptococcus serum. The injection consisted of 10 cubic centimetres of

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serum. This injection was given in the afternoon, and by the next morning the temperature had fallen two degrees, the pulse become slower by thirty beats. The aspect of the patient was much better. The vaginal discharge had decreased in amount, had lost its foul smell, and was much cleaner.

Alex. J. Anderson cities a case of puerperal septicemia which had run for one week, and, the patient being in a very low condition, they gave injections of antistreptococcus serum. The first injection was given on a falling temperature. In one hour and a half it was down to 99.4° but three hours later went up to 102°. The second injection was given the next morning, and the temperature, which was 101.8°, went up to 103.8°, but got down below normal by 10 next morning. The next day another injection was given when the temperature was going up, and had the effect of keeping it down to 101.4°. The following day the temperature was 99.4°. An injection was given and the temperature fell below normal and remained there three days. He used ten cubic centimetres of the serum at a time.

S. J. Barker reports a case successfully treated by serum.

Sergueu reports a case of acute sepsis in which injections of Marmorek's serum were apparently followed by success. The patient was a primipara, 21 years old, who at the end of gestation suddenly became septic. No discoverable cause. The emptying of the uterus brought no relief, and subcutaneous saline infusions produced no improvement. As a last resort 20 cubic centimetres of Marmorek's antistreptococcic serum were injected, and, whether *post hoc* or *propter hoc*, from that time improvement began.—*Journal Obstet.*

## AIR EMBOLISM IN PLACENTA PREVIA.

Hubl publishes two cases from Braun's clinic. The first was a woman 40 years old with a rachitic pelvis. The patient collapsed while version was performed. Postmortem showed the right side of the heart filled with air. The upper margin of the placenta was detached, and a blood vessel the size of a crow's quill was wide open and probably formed the entrance gate of the air. In the second case death occurred about nine hours post partum, also after version. Death was preceded by several attacks of collapse. No postmortem in this case. The author discusses the differential diagnosis of chloroform collapse and air em-

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bolism. In the latter there is usually a sudden escape of liquor amnii and a consequent rush of air into the cavity of the uterus.

## APPARENT DEATH OF THE NEW BORN.

Keiffer believes that attempts to resuscitate apparently still-born children are frequently given up too soon. He cites a case in which breathing did not begin until thirty-five minutes after commencing artificial respiration, and another in which fifty minutes elapsed before this result was obtained.—*Journ. Obstet.*

## HEART DISEASE FROM AN OBSTETRICAL POINT.

A. H. Wright believes that a woman having a heart lesion which is compensated should not be prevented from marrying. Abortion should not be induced on a woman with heart disease, unless very serious symptoms are present. Premature labor should be seldom or never induced. Mitral stenosis is the most serious heart lesion during pregnancy and labor; aortic stenosis comes next, then probably aortic incompetency. Mitral insufficiency is the least serious lesion.

*Treatment during Pregnancy.*—Administer the following according to indications: strychnine, digitalis, or strophanthus, cathartics, nitrite of amyl, nitroglycerin; and regulate the diet.

*Treatment during Labor.*—Keep up the action of digitalis, especially during first stage. Give strychnine and stimulants, if required, and chloroform. As soon as the first stage is completed deliver with forceps. The patient must be watched very carefully during the third stage, as this is the most serious period.—*Jour. Obstet.*

## OBSERVATION ABOUT SORE NIPPLES.

According to Platzer, sore nipples are caused through biting and pulling during the process of nursing. The best treatment of fissures are applications of carbolic acid solution. Ulcerations should be washed with corrosive sublimate solution and dusted with dermatol. In mastitis nursing must be interrupted, the breasts compressed, and ice bags applied. Among 1,000 nursing puerperæ in Kezmarsky's clinic sore nipples were observed in 51.5 per cent.—*Jour. Obstet.*

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THE
# CANADA MEDICAL RECORD
PUBLISHED MONTHLY.

*Subscription Price*, $1.00 *per annum in advance. Single Copies*, 10 *cents.*

Make all Cheques or P.O. Money Orders for subscription, or advertising, payable to JOHN LOVELL & SON, 23 St. Nicholas Street, Montreal, to whom all business communications should be addressed.

All communications for the Journal, books for review, and exchanges, should be addressed to the Editor, Box 2174, Post Office, Montreal.

# Editorial.

## THE TRAIN.

We copy the following from the *Stylus*, a medical journal published in St. Louis, Mo., and most heartily endorse every word that it contains. The train has arrived in Montreal, and the dust that it creates as it sweeps along our streets almost chokes one. More than once, when following in its wake, we have been obliged to lessen our gait so as to be able to breathe air not composed of about half dust. We have heard ladies complain of the dust raised by carriages on our unwatered streets, while their trains raised almost as much on our unwatered sidewalks. Of a truth, if these disgusting trains are not abolished, we will be compelled to ask that our sidewalks be watered as well as our streets. We very much doubt whether, if this were done, it would induce the ladies to wear sensible skirts. It at all events would render life pleasant to those whom necessity compelled to walk behind them, and they could collect on these streets, without annoyance to others, all the filth they desire—no, not desire, yet nevertheless get.

"There are many kinds of trains, but the dirtiest, the most vulgar, the most to be avoided, the most horribly suggestive, is the long dress train on the dirty street. It is not a

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matter of fashion, it may not be a matter of health, although our hygienists, with good reason, think so; it is mainly a matter of dirt—of vile, disreputable, unmitigated, dirty dirt. We saw a beautifully-dressed young lady on Broadway yesterday. Her little hands were daintily gloved, her dress was the latest and the best, her face was pure and sweet and gentle, but then—

"She was walking on a pavement that had not been swept—except by others of her exclusive class—since morning. Some of the things on that pavement are not to be described or even named, for chewers and consumptives and coach dogs had been there and left their mark. Miss Vere de Vere swept on while a cloud of dust and other things around and underneath arose to do her homage—Bah.

"Is the picture too strong? It is at least true."

## JEAN LUKIN LEPROHON, M.D.

The death of this well-known Montreal medical man took place on the 23rd of May from pneumonia, at the age of 78 years and two months. He filled at one time a prominent place among the profession in Montreal by whom he was highly esteemed. Of late years advancing age obliged him to reduce his work, so that among the younger members he was hardly if at all known. Dr. Leprohon belonged to a very old French-Canadian family, his great-grandfather coming to Canada in 1758 as an officer in a French regiment, and, after the conquest, he settled in the country. He graduated from McGill University in 1843, so that he was among the oldest, if not the oldest, of its living medical graduates. On the formation of the Medical Faculty of Bishop's College, he accepted the Professorship of Hygiene, which position he filled for several years with much ability. He was one of the three original founders of the Women's Hospital of this city—the sole survivor being Sir William Hingston. He also for years took a very active interest in the Montreal Dispensary, of which at his death he was a consulting physician. He had also filled the office of Vice-President of the College of Physicians and Surgeons of the Province of Quebec. Among the

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older members of the profession in Montreal he was held in high esteem. He was a typical specimen of that *politesse* which is so characteristic of our French-Canadian brethren.

## FERROL.

Since our attention was drawn to this preparation, which is advertised in the RECORD, we have used it somewhat extensively in both private and hospital practice. The results on the whole have been very satisfactory, practically bearing out all that is claimed for it. In one or two instances it was not well borne, but in the great majority it was readily taken and easily assimilated. This preparation is not presented for sale to the general public, and is not advertised in ordinary newspapers. On the contrary it is only advertised in medical journals and presented to the medical profession for prescription. Among the profession in Toronto it is largely used, and what is most unusual, nearly every physician of any note in that city has above his signature certified to its efficacy and to his faith in it. Any preparation certified to by such men as Drs. Geikie, Temple and Ryerson must at least be worth investigation. It was these and other names which induced us to use Ferrol, and we have no regret that we did so.

## THE LACTOPEPTINE MEDICAL ANNUAL FOR 1900.

The New York Pharmacal Association, whose headquarters are at Yonkers, N. Y., have sent us a copy of their Medical Annual. It is beautifully printed and covered. It also contains some copies of unique medical engravings, which cannot help being viewed with much interest. The reading matter is useful and some of it very amusing. The Association will be glad to send a copy to any physician who may ask for it.

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## PERSONAL.

Dr. Wyllie has been appointed Professor of the Practice of Physic in Edinburgh University, rendered vacant by the death of Sir Thomas Grainger Stewart. He took his M.D. from Edinburgh University in 1865. He had been connected for many years as a Lecturer on Medicine with the Extra-Academical School.

Dr. E. R. Brown (M.D., Toronto University), of Montreal, was in the accident which took place on the 28th of May on the Canadian Pacific Railway, near Labelle, P.Q. He was much shaken up and received a number of bruises, but fortunately escaped serious injury.

# Book Reviews.

**Gynecology**—A manual for students and practitioners, by Montgomery A. Crockett, M.D., adjunct professor of Obstetrics and Clinical Gynecology, Medical Department, University of Baffalo; attending Gynecologist to the Buffalo General and Erie County Hospitals. Series edited by Bern B. Gallaudet, M.D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons Columbia University, New York; Visiting Surgeon Bellevue Hospital, New York. Illustrated with one hundred and seven engravings. Lea Brothers & Co., Philadelphia and New York.

In the author's own words "a book can be too condensed or too expanded. In the aim to avoid either extreme, the present volume endeavors to give an intelligent idea of the present status of gynecology. To be valuable, such a work must be representative. The writer has therefore endeavored to reflect the accepted views of the foremost authors and practical gynecologists as expressed in the rich standard literature of the subject. His own experience in practice and teaching has been embodied, and has at least served to make his presentation more uniform and clear." We think that Dr. Crockett has succeeded admirably in his endeavor to write a text book for students; everything is briefly and clearly stated. The busy practitioner will also find it very handy for consulting, and for refreshing his memory while driving from case to case. The author only claims that it is a pocket text book, but we think it is all that he has claimed for it, and even more. It is thoroughly up to date and should have a large sale.

A. L. S.

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**Saunders' American Year-Book of Medicine and Surgery.**—Being a yearly digest of scientific progress and authoritative opinion in all branches of medicine and surgery, drawn from journals, monographs and text-books, of the leading American and foreign authors and investigation: under the general editorial charge of George M. Gould, M.D. In two volumes of about 600 pages each, on Medicine and Surgery, respectively, each volume complete in itself and for sale separately, cloth $3 net, half morocco, $3.75 net. Published by W. B. Saunders, Philadelphia, 1900.

Volume II, of Saunders' American Year-Book of Medicine and Surgery is devoted to Surgery, and is not quite so large as volume I, which treats of the medical subjects. The diligent editors, to meet the great demand for this work, have gathered together an abundant supply of material, and this has led the publishers to issue it, for the first time this year, in two volumes, each complete in itself.

This arrangement has a double advantage. To the physician who uses the entire book, it offers an increased amount of matter in the most convenient form for easy consultation, and without any increase in price; while the man who wants either the medical or surgical section alone secures the complete consideration of his branch without the necessity of purchasing matter for which he has no use. This work is deservedly popular, and ranks as one of the best yearly compendiums now published. Volume II. treats of the following subjects: General Surgery, Obstetrics, Gynecology, Orthopedic Surgery, Ophthalmology, Otology, diseases of the Nose and Larynx and Anatomy. The subjects are dealt with by men well known by their constant contributions to medical and surgical literature and scientific progress; *e.g.* Keen, Dabosta, Hirst, Darland and Baldy. All the features of the work that have in the past proved so valuable will be retained.

The publisher has done his work up in the usual attractive and serviceable finish, and the type is of such size and character as to prove attractive to the eye, so that the latest and best is here given in a very convenient form.

R. C.

**Saunders' American Year-Book of Medicine and Surgery—Medicine.**—As intimated above, the Year-Book is now published in two volumes—one devoted to Surgery, the other to Medicine. That this is an advantage is without question. I find it quite impossible to criticise the contents of the Medical volume, for it is simply a collection of the current medical literature of the past year. This clearly shows that our leading scientific workers have, during that time, not been idle; on the contrary the amount of material collected proves that in spite of much to discourage, some advance of a practical character has been made. It, however, is but slight, and it must be admitted that pure Medicine still lags behind Surgery in its advancement. Indeed at times I am inclined to think that we have

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been unfortunate in casting aside the old to take hold of the new. Still as things go we must follow the crowd, being conservative enough to judge how far we must go before being obliged to cry "halt." The contributors to this volume are all men eminent in their special departments, and they have done their work well.

F. W. C.

**The International Medical Annual and Practitioners' Index.**—A work of reference for Medical Practitioners, 1900. Eighteenth year. New York, E. B. Treat & Co., 241-243 West 23rd street; Chicago, 199 Clark street. Price $3.00

This annual is an established favorite with Canadian Medical men on account of the editors of a great many sections being practitioners attached to British Hospitals either in the British Isles or India. The same condition prevails in the present volume, as thirty-three out of the forty-two editors or collectors are practitioners residing in Great Britain. Their work, however, is fully equalled by the American Editors, among whom are Dwight Chapin, Samuel Gant, G. M. Hammond and H. P. Loomis of New York. Its contents do not show that during the past year there has been any special extension of our Therapeutic knowledge. They prove, however, that disease has been studied closely, and that a more exact diagnosis is as a consequence now possible. Treatment, however, still lags behind. The field is fully covered in this volume, and the selections have been made with care, and in some cases are more fully copied than we have found in some other similar volumes. It is well worth its cost.

F. W. C.

**The International Text Book of Surgery,** by British and American Authors. Edited by J. Collins Warren, M.D., and A. Pearce Gould, M.S., F.R.C.S. In 2 Volumes. Price, cloth $5.00; sheep or ½ M. $6.00 Pub. W. B. Saunders, Philadelphia.

The second Volume of this work takes up regional surgery, and is illustrated with many excellent cuts from original photographs and several colored plates. The division into regions is very good, and each author deals most thoroughly with his division. It is hardly just to single out one or two authors for special praise, as the entire work is so creditable, but Dr. H. Holbrook Curtis in his chapter on Surgery of the Nose shows clearly the recent advances in the surgical treatment of the accessory cavities of the nose. His illustrations of before and after operations in the case of nasal deformities is most interesting. In the chapter on Surgery of the Neck A. Pearce Gould discusses many interesting points. In dealing with Parotid Bubo he speaks of intraperitoneal operations and peritonitis as causes, adding, that "no explanation can at present be given of the association of this secondary suppuration with operations within the peritoneal cavity." Possibly this condi-

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tion can be considered a reversion of the phenomenon of occhitis, ovaritis or metritis following mumps.

Surgery of the Breast by J. Collins Warren is splendidly illustrated and concisely written. A careful perusal will aid in forming a diagnosis in cases of suspected malignancy.

Taken together, these two volumes cannot but be heartily recommended as a thoroughly comprehensive and up-to-date production. G. F.

**Martin and Rockwell's Chemistry and Physics**—A. Pocket Text-Book of Chemistry and Physics. By Walton Martin, M. D., and William H. Rockwell, Jr., A.B., M.D., of the College of Physicians and Surgeons, New York. In one 12mo. volume of 336 pages, with 137 illustrations. *Just Ready.* Cloth, $1.50, *net.* Flexible red leather, $2.00, *net.* Lea Brothers & Co., Philadelphia and New York.

An acquaintance with the general principles of Chemistry and Physics is absolutely necessary for the student who would intelligently follow such important subjects of a medical curriculum, as Physiology, Materia Medica, Hygiene, etc.

But the subjects are so very wide that every lecturer on Chemistry in a Medical College finds himself again and again confronted with the question : " How much and what portions of Physics and Chemistry shall I lay before my students ? " This book is an attempt to answer this question, and is a very creditable attempt.

In the first 182 pages we find brief but terse and vigorous statements, as to mode of occurrence, preparation and properties of the more important elements and compounds. In Organic Chemistry, only the Methane and Benzene series of hydrocarbons and their derivatives are taken up. Special attention is given to the compounds " which are of medical interest not only medicinally, but in physiological chemistry ".

The second part of the book, 187 pages, is devoted to Physics, and is a very satisfactory treatise on elementary physics, and takes note of the latest developments, as witness the brief reference to wireless telegraphy. In the writer's opinion, the book would be improved by reducing the portion devoted to Physics, and enlarging that allotted to Chemistry. The work seems disproportioned, when we find the part devoted to Physics discussing the construction of the telephone and wireless telegraphy ; but look in vain in the chemical portion for any reference to such important substances as Calcium Carbide and Acetylene, for example.

We find also a few statements throughout the text that are scarcely correct, and which we expect will be altered in another edition. Among them we may mention the statement on page 72 " seventy elements now known," whilst symbols are given for more than that number on page 22. Then again on page 76 the statement is made that " *potassium* Iodide occurs in sea water and is taken up by sea weeds ; " whilst this may not be absolutely in-

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correct, it would be more accurate to write thus of *Sodium* Iodide. On the whole, however, we are favorably impressed with the volume, and can recommend it as a text book for medical students if used in connection with a course of lectures and demonstrations in Chemistry and Physics.

J. T. D.

**The Essentials of Hematology.**—A practical guide to the clinical examination of the blood for diagnostic purposes. Illustrated. Published by the Palisade Manufacturing Company, Yonkers, N.Y.

This little work on the clinical examination of the blood is published by The Palisade Manufacturing Co., makers of "Hemaboloids." Starting with a careful description of the instruments needed, and their methods of use, the author passes on to the simple methods of staining best suited for blood work.

The brochure is carefully compiled, and the information it gives is accurate and up to present day requirements. It is well illustrated.

A.B.

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# PUBLISHERS DEPARTMENT.


## SANMETTO ENDORSED AFTER WATCHING ITS EFFECTS IN SEVERAL HUNDRED CASES OF GENITO-URINARY DISEASES.

It gives me great pleasure to add my testimony to that of the many eminent physicians in this city and elsewhere, attesting the wonderful curative value of Sanmetto. In nearly all genito-urinary ailments, especially of a chronic nature, it is simply invaluable. I consider Sanmetto almost a specific for chronic prostatitis, especially in old men, where more or less hypertrophy exists; also in weakness of the generative system, it has wonderful power in restoring waning sexual strength. This is my first testimonial for any medicine, but having prescribed Sanmetto ever since its introduction to the profession, and watched its effects in several hundred cases, I feel that I need not hesitate to endorse it.

Chicago, Ill. L. E. MILEY, M.D.
Grad. 1881, Michigan University; Member American Med. Assn., Member Illinois State Med. Assn., Member Chicago Med. Soc.

## SANMETTO IN ENURESIS-NOCTURNA.

Dr. L. L. Gray, St. John, Mo., reports the outline of a case of enuresis-nocturna, treated with Sanmetto, several years ago. The case was that of a maid thirteen years of age, who had suffered with enuresis from infancy. She was old enough to realize her condition, and keenly felt its effects—acted as though she thought every one she met knew her troubles, and consequently she was shy, unsociable, ashamed to be seen in company, and strangers would ask if she was entirely sane. He gave her a bottle of Sanmetto, told her mother to give her all assurance that it would cure her, if properly taken. A second four ounce prescription verified the truth of his statement. He says it did cure her for all time, and to-day she is a perfectly formed young lady, intelligent and sociable, the downcast countenance gone, and life is again worth living.


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CANADA
# MEDICAL RECORD

JULY, 1900

## Original Communications.

### FOR "THAT NOSE."

By GIFFARD KNOX, M.D., Westfield, New Jersey, U.S.

He "would give anything" to be rid of it.

What? "That nose," red, bulbous, deformed.

Not the nose itself, but the deformity, the high color, the manifest deformity. "That nose," indeed! It is by no means a rare condition, and because of this fact it would seem as though a successful treatment should have been defined long ago. Instead—the records do not seem to justify any such conclusion. The practitioner's disposition is either to make light of the disorder or to ignore it altogether."

"It is no disease. Stop drinking, and it will disappear."

That is your opinion whether you say it or not. But you are not honest with yourself in saying this. It *is* a disease.

Dignified as "acne rosacea?" Not necessarily; neither is it necessarily the *fons et origo* of rhinophyma. But, beyond question, it is a disorder of the most stubborn character, and characterized by a chronicity that is disheartening to patient and physician alike. Both know that the aggravation is due to a complicated condition of affairs produced by indulgence in alcoholics. The disorder is nothing if not of a marked character—of such a marked character as to attract attention. *Pfundnase* is the expressive name that the Germans bestow on it. The patient, despairing of ever getting well, or, as he says, of "ever getting over that nose," offers his "anything" for the good riddance.

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He asks bread, and the physician gives a stone. The "anything" crystalizes into a "You must stop your alcoholic habits." Job's comforter! You know as well as he does, perhaps better, that if he becomes as temperate as a Woolley or a Gough, the malady remains to mock and menace.

The tendency to the peculiar hypertrophy of the tissues of the nose is never uniform. In some it ceases after an uncertain length of time, in others, however chaste the habits may be, it continues. In others still, where there is but a minimum of exasperating irritation, it goes on to a degeneration of tissues. In still others a deformity supervenes which is something appalling in its dimensions,—a pendulous nose with rugous, shining, red surface.

It is not necessary to describe the disorder pathologically; it would be a work of supererogation. There are, however, certain points to be corrected as mistakes. On ocular examination it would seem as if the formation was one of dense fibrous tissue only, and occurrent in the cutaneous tissue. But, as we study such cases, we find, first of all, that the skin covering the hypertrophied mass is thin instead of being at all hypertrophied. In point of fact it might better be described as atrophied. It is healthy in every sense. It is not fibrous. In some cases the *rete mucosum* is thickened, but this is not uniform.

The openings of the sebaceous glands are large and patulous, and the glands themselves are encysted. Invariably these glands are numerous and distended with fatty material. These form the prominent element in the disease, as this condition of abnormal enlargement of the sebaceous glands becomes secondary to a connective tissue hypertrophy, which by its development occludes a portion of the sebaceous glands, which then go on secreting, and thus producing a retention of sebum, which in turn acts as an irritant, and thus stimulates to further hypertrophy. There also ensues upon this an enlargement of the blood vessels, together with some new formation of blood vessels. These blood vessels consist of arteries with hypertrophied coats and of dilated veins, with their coats unchanged.

If now we photograph the microscopal condition, we find

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(1) that the epidermis is unchanged, (2) that the corium may or may not be hypertrophied. (3) that the number as well as size of the sebaceous glands appears increased, (4) that the blood vessels are also enlarged and more numerous, (5) that the appearance is strongly suggestive of a derivation from the subcutaneous adipose tissue, and (6) that the compensating hypertrophy is adipose rather than fibrous. Auxiliary pathological facts are (*a*) seborrhœa, (*b*) stasis of the blood in the vessels, and (*c*) a disagreeable itching. There is no tendency to suppuration, although under the influence of irritation the glands may become suppurating sacs. (In operations for rhinophyma, it is stated to me that the sutures are "always apt to ulcerate out." This is quite probable.)

"That nose" then represents an organ with the cellulo-adipose structures over-distended, and with the morbid accumulation mechanically interferent with nutrition.

While it is true that "that nose" condition may sometimes have nothing to do with abuse of alcoholics, still it is a condition manifesting mal-assimilation or mal-nutrition from some other cause of allied kind. If we will but receive it, "that nose" is a form of obesity. We have cases of unsightly abdominal fat, chin, facial, bust and hip fat. And we have also *nose fat.*

Now as to earning that "anything to get rid of it" fee. The indication is to inhibit or control the disproportionate activity of fat-cell nutrition by placing less fatty pabulum at the service of the absorbents and thus preventing further infiltration or super-storage of the adipose matter.

The primary indication points to a rational dietary, and I scarcely need to say that there is a wide choice for a system to limit the supply of fat-forming elements. The Bantingism that interdicts all fats, sugar and starches is perhaps unexcelled. As for medicinal treatment:—I am agnostic. The permanganate of potash and bromide of ammonium are both excellent in diminishing deposition and hastening the retrograde metamorphosis of fat; but both tend to cause gastric catarrh. The Cathell treatment for obesity is equally as good for nasal as for abdominal corpulence. I heartily favor it. I would, however, suggest a modification, and it is one that

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has commended itself by large experience. Instead of giving the Vichy one day and the Kissingen the next, I order the Vichy for two successive days, a glass after each meal, then the Kissingen for one day, the Vichy for the fourth, the Kissingen for the fifth and sixth, the Vichy for the seventh, the Kissingen for the eighth and ninth, and so on. This plan of treatment leaves nothing to be desired. It is well nigh specific. The rationale is apparent. The water may be taken at the fountain, or the granular or effervescing salt post-prandially.

It is also indispensable that during the course of mineral water the patient should take before each meal ten drops of eucalyptol, preferably the Australian or Sander eucalyptol. We are, perhaps, too over-confident in this year of grace, but if the patient is in earnest in getting rid of "that nose," the eucalyptol will accomplish it, he meanwhile taking the waters in lieu of his alcoholic beverage. The eucalyptol acts on the abused tissues, and the waters correct the depravity in appetite.

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# Selected Articles.

## THE WAR IN SOUTH AFRICA.

### THE EPIDEMIC OF ENTERIC FEVER AT BLOEMFONTEIN.

By A. CONAN DOYLE, M.D.

(*To the Editor of the British Medical Journal.*)

The Langman Hospital, South African Field Force,
Bloemfontein, June 5, 1900.

DEAR SIR,—You were good enough to suggest when I left England that I should send you some notes upon any points which might strike me. The pressure of work has prevented me from complying with your request, and even now I feel that you will find these comments of a very scrappy character.

When the nation sums up its debt of gratitude to the men who have spent themselves in this war I fear that they will almost certainly ignore those who have done the hardest and the most essential work. There are three classes, as it

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seems to me, who have put in more solid and unremitting toil than any others. They are the commissariat, the railway men and the medical orderlies. Of the three, the first two are the most essential, since the war cannot proceed without food and without railways. But the third is the most laborious, and infinitely the most dangerous.

### THE OUTBREAK OF ENTERIC FEVER.

The outbreak of enteric among the troops in South Africa was a calamity the magnitude of which had not been foreseen, and which even now is imperfectly appreciated. We naturally did not dwell too much upon it while the war was in progress. But it was appalling in its severity, both in quantity and quality. I know of no instance of such an epidemic in modern warfare. I have not had access to any official figures, but I believe that in one month there were from 10,000 to 12,000 men down with this, the most debilitating and lingering of continued fevers. I know that in one month 600 men were laid in the Bloemfontein Cemetery. A single day in this one town saw 40 deaths. These facts would have stiffened the resistance at Pretoria if they had been generally known. It is only now, when the worst is past, that they can be talked of.

### THE HOSPITAL ORDERLY.

How was this unforeseen and unprecedented crisis grappled with? Entirely by the efforts of the medical men and by the devotion of the orderlies. When a department is confronted by a task which demands four times more men than it has, the only way of meeting it is for each man to work four times as hard. This is exactly what occurred, and the crisis was met. In some of the general hospitals orderlies were on duty for thirty-six hours in forty-eight, and what their duties were—how sordid and obscene—let those who have been through such an epidemic tell.

He is not a picturesque figure, the orderly, as we know him. We have not the trim, well-nourished army man, but we have recruited from the St. John Ambulance men, who are drawn, in this particular instance, from the mill hands of a northern town. They were not very strong to start with, and the poor fellows are ghastly now. There is none of the dash and glory of war about the sallow tired men in the dingy khaki suits—which, for the sake of the public health, we will hope may never see England again. And yet they are patriots, these men; for many of them have accepted a smaller wage in order to take on these arduous duties, and they are facing danger for twelve hours of the twenty-four,

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just as real and much more repulsive than the scout who rides up to the strange kopje or the gunner who stands to his gun with a pom-pom quacking at him from the hill.

Let our statistics speak for themselves, and we make no claim to be more long-suffering than our neighbours. We have 3 on the staff (Mr. Gibbs, Mr. Scharlieb and myself). Four started, but one left us early in the proceedings. We have had 6 nurses, 5 dressers, 1 wardmaster, 1 washerman and 18 orderlies, or 32 in all, who actually came in contact with the sick. Out of the 6 nurses, 1 has died and 3 others have had enteric. Of the 5 dressers, 2 have had severe enteric. The wardmaster has spent a fortnight in bed with veld sores. The washerman has enteric. Of the 18 orderlies, 1 is dead and 8 others are down with enteric. So that out of a total of 34 we have 17 severe casual ies—50 per cent.—in nine weeks. Two are dead and the rest incapacitated for the campaign, since a man whose heart has been cooked by a temperature over 103° is not likely to do hard work for another three months. If the war lasts nine more weeks, it will be interesting to see how many are left of the original *personnel*. When the scouts and the Lancers and the other picturesque people ride in procession through London, have a thought for the sallow orderly, who has also given of his best for his country. He is not a fancy man—you do not find them in enteric wards—but for solid work and quiet courage you will not beat him in all that gallant army.

## ANTITYPHOID INOCULATION.

There is one mistake which we have made, and it is one which will not, I think, be repeated in any subsequent campaign. Inoculation for enteric was not made compulsory. If it had been so I believe that we should (and, what is more important, the army would) have escaped from most of its troubles. No doubt the matter will be fully threshed out in statistics, but our strong impression, from our own experience, is that, although it is by no means an absolute preventive, it certainly modifies the course of the disease very materially. We have had no death yet (*absit omen*) from among the inoculated, and more than once we have diagnosed the inoculation from the temperature chart before being informed of it. Of our own *personnel* only one inoculated man has had it, and his case was certainly modified very favourably by the inoculation.

## THE SOLDIER IN HOSPITAL.

Of the courage and patience of the soldiers in hospital it

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is impossible to speak too highly. We have had 500 cases pass through our hands, and can speak now from a fairly large experience. I had always imagined that in every large army there must be a minority of skulkers and shirkers, but they are singularly absent in the South African Field Force. I have not had more than two or three cases in my wards which bore a suspicion of malingering, and my colleagues say the same. They are uniformly patient, docile and cheerful, with an inextinguishable hope of "getting to Pretoria." There is a gallantry even about their delirium, for their delusion continually is that they have won the Victoria Cross. One patient, whom I found the other day rummaging under his pillow, informed me that he was looking for "his two Victoria Crosses." Very touching also is their care of each other. The bond which unites two soldier pals is one of the most sacred kind. One man shot in three places was being carried into Mr. Gibb's ward. I lent an arm to his friend, shot through the leg, who limped behind him. "I want to be next Jim, 'cos I'm lookin' after him," said he. That he needed looking after himself seemed never to have occurred to him.

### THE SPECIAL HOSPITALS.

I do not think that any men have ever expended money better than those who fitted out the private hospitals. The officers of the Army Medical Department freely admit that they do not know what they would have done without their aid. They arrived out here at the very moment when the sickness was becoming alarming, and they took their share of the strain when the epidemic was at its height. The large general hospitals found it difficult to get to work on account of the pressure on the line which prevented them from getting up their bulky equipment, but the private hospitals, more compact and mobile, got to work almost at once after their arrival. The pressure was severe. Our own hospital, with equipment and *personnel* for 100 cases, had 150 cases, most of them virulent Paardeburg enterics, shot upon them, and had to cope with them as best they might. But the men had come out to work, and the orderlies, though untrained, never once grumbled at the great exertions which were called for. Without the Yeomanry, the Portland, the Irish, the Scotch, the Welsh and the other hospitals fitted up by private effort, and manned by volunteers, it is difficult to see how the epidemic could have been met.

### THE WORK OF THE R.A.M.C.

There is sure to be some adverse criticism of the Army

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Medical Department after the war, because they have had to meet so difficult a situation with such inadequate resources that it is impossible that there should not be particular instances where the machinery has broken down. A captious critic could quote cases of an overfilled, undermanned hospital without medical necessities in one place, or of hardships endured by the sick and wounded in another. How can it be otherwise when a Department which is sufficient for the needs of two army corps has to provide for the wants of 200,000 men with typhoid raging among them? Taking it on the whole, the Department has been well organized and well worked, and has met an unforeseen and exceptional state of things with remarkable success.

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## A CASE OF PNEUMONIA TREATED WITH ANTIPNEUMOTOXIN.

By CHARLES B. CANBY, M.D.

### CLINICAL HISTORY.

I was called on December 20 to see E. T., twenty years of age, who worked in the moulding-room of a large stove factory. He had an attack of pneumonia five years ago. His present illness began on the 18th, and may have been in a measure due to his having worked all day (on the 16th) in wet clothing.

The attack began with a chill on the 18th of December. When seen at noon on the 20th he was in bed, with cough and pain in the left side. He expectorated a large amount of rusty sputum, and had a temperature of 104°, pulse 120, and respiration 24. The physical signs were, increased vocal fremitus, bronchial breathing and dullness on percussion over the lower lobe of the left lung. The crisis apparently occurred on the 24th. Up to this time the patient had been treated with alcohol and digitalis, with one or two doses of morphia to quiet pain. On Christmas day, feeling very much better, the patient most imprudently left his bed, dressed and went into the yard.

On the 26th I found him in bed delirious, with a temperature of 104°, respiration 56, and a pulse that could not be counted. The pain was severe on the right side, and the physical signs were those of consolidation of the right lower lobe. At 6 o'clock in the evening his temperature had risen to 105°, his pulse was still uncountable, and his respirations were 56 to the minute. At this visit I injected 12 c. c. of antipneumotoxin. In three hours his temperature fell two

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and one-half degrees, he was sweating freely, and his respiration came down to 40, but his pulse remained uncountable.

At 10 o'clock on the morning of the 27th his temperature was 99°, respiration 24 and pulse 96. Notwithstanding his apparent improvement I gave him again 12 c. c. of the antitoxic serum.

His improvement was not interrupted, and on the 8th of January, 1900, he was able to return to his work.

This clinical history, showing a left pneumonia having crisis on the eight day under ordinary treatment, followed by a much severer right pneumonia which came to apparent crisis in two days, suggests that the antitoxin might have produced a much earlier crisis than the first attack would have led one to expect. Indeed, the second attack seemed to be of extraordinary severity and likely to result fatally. One must not draw conclusions from a single case, but the record of this case seems worth publishing, because it seems, in effect, to have been two attacks of pneumonia in the same subject, treated upon widely different lines, and with strikingly different results.

Through the courtesy of my friend, Dr. Geo. H. Everhart, I am able to append the following brief notes of two cases of pneumonia in which he used antipneumotoxin.

Eli P. J. was seized with a chill on January 13. When first seen on the night of January 14, he had a temperature of 103°, pulse 110, rapid respiration. cough, rusty sputa, and the physical signs of consolidation of the lower lobe of the right lung. On the following morning, the 15th, the man was in substantially the same condition, and in the evening of that day he received a hypodermic injection of 10 c. c. of antipneumotoxin. On the morning of the 16th (fourth day in bed) he was in a profuse sweat, having a temperature of 99°, and with pulse and respiration much improved. On the 20th his temperature was normal, and on the 24th was up and apparently well.

On Tuesday evening, February 1, Kate C., aged twenty years, was found ill with pneumonia, the signs of consolidation being apparent everywhere over the right lung; temperature 103°, pulse 108, respiration 40. On the morning of February 2, her temperature being at the time 103° and pulse 110, she received by hypodermic injection 10 c. c. of antitoxic serum. At the evening visit her temperature was 102°, pulse 108, respiration 33. On the morning of February 3, her temperature was normal, pulse 80 and respiration 20. She was in all respects comfortable, and remained so until the 5th, when she sat up in bed. In the evening she had a chill and a rise of temperature to 105°, with a respiration rate

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of 32. Next morning she was again injected with 10 c. c. of antipneumotoxin, her temperature then being 104.2°, pulse 113, respiration 32.

As happened after the first injection, very little change in her condition was apparent at the evening visit, when her temperature was 104°, pulse 108, respiration 32. On Feb. 7, twenty-four hours after the second injection, her temperature was normal, pulse 70, respiration 18. From this time on, her convalescence was uninterrupted, and on the 12th of February she was discharged.

I am indebted to Dr. Louis F. Frey for the following notes of a case in his practice, together with Dr. Stokes' report upon the sputum:

W. S., driver of an express wagon, had a chill on the afternoon of January 30, followed by fever, headache and pain in the chest and abdomen, I saw him for the first time at 9 o'clock in the evening of January 31. He had a temperature of 103°, pulse 120, respiration 38, cough and rusty expectoration. The physical signs were moderate percussion dullness, increased vocal fremitus, and fine crepitant and bronchial rales on the left side.

"He was put on five-grain doses of carbonate of ammonia. On the following morning he was no better, his temperature having risen to 103.6°, pulse 138, respiration 40; at 4 p.m. his temperature was 103.8°, pulse 140, respiration 42. At this visit I gave him 20 c.c. of antipneumococcic serum. At 10 p.m. temperature 103.6°, pulse 102, respiration 28, headache and pain better, but percussion dullness much increased. A second dose of serum, 20 c.c. was injected. At 9 a.m. on the following day (February 2), temperature 99, pulse 76, respiration 28; next morning his temperature was 98.4°, pulse 70, respiration 23, and he had slept well during the night.

"Up to this date (February 14) his temperature has remained normal, and he seems well, but I have not yet permitted him to go out.

"Two specimens of his sputum, submitted to Dr. Wm. R. Stokes, were reported on as follows:

"February 1, 1900.—The sputum shows a dusty light-brown color, and is streaked with blood. Fresh examiuation shows areas where the red-blood corpuscles are in excess when compared with the pus cells, and other areas where the pus cells are greatly in excess. Specimens stained with Stirling's gentian violet show a few typical pneumococci, with unstained capsules, but no organisms are seen inside the pus cells. There are also present numerous large cocci and a few bacilli.

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"February 2, 1900.—The gross appearance of the sputum is the same as on yesterday, and the examination of a fresh specimen shows no change. Specimens stained with gentian violet show a greater number of pneumococci, and at times these organisms are included within the protoplasm of the pus cells, showing a phagocytosis. There are very few other organisms present." — Abbreviated from *Maryland Medical Journal, March*, 1900.

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## ALCOHOLISM.

By CHARLES J. DOUGLAS, M.D., Boston.

There are few chronic diseases that will more surely yield to proper medical treatment than alcoholism. Proper treatment can be given, however, only when the patient has been removed from his home and customary surroundings. Any practitioner who has attempted to treat alcoholics at their homes will admit that it is practically impossible to more than temporarily relieve such patients. Still, a removal may be made that will be to the patient's disadvantage. Confinement in a jail is worse than no treatment at all, and an insane asylum is almost as objectionable. The so-called "homes" for inebriates are another class of worse than useless institutions, in which an intoxicated man is thrown into a cell and allowed to rave without stimulants till sober, or till death relieves his suffering. A humane man would not treat a dog with such barbarity. The sudden withdrawal of alcoholic liquors in this way not only causes the patient intense suffering, but, after a protracted spree, is the principal cause of delirium tremens and death. The withdrawal of alcohol should be gradual, its place being temporarily taken by such remedies as hydrastis or capsicum, or other indicated remedies. I have followed this course for years in the treatment of many hundreds of alcoholics, and my cases of delirium tremens never go beyond the first symptoms, and I have never had a death. To successfully treat alcoholism the patient should be removed to a sanitarium where the treatment of such ailments is made a specialty. Here he can be under the constant care and observation, day and night, of physicians and attendants whose special training and experience enable them to adopt the best methods in the management of the changing conditions of this peculiar disease. Fortunately, there are now sanitariums of this kind in many parts of the United States. I, of course, do not here have reference to the quack "cures"

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in which secret nostrums are dispensed in a routine way by a physician who knows nothing of their composition. No self-respecting practitioner can take his patients to such an institution. But I refer to sanitaria that are ethically conducted, to which a physician can take his alcoholic cases and receive any information he desires regarding the remedies employed in the treatment of his patients, and where he will be cordially welcomed as a consultant by the house physician.

In treating of the pathology of this disease it is customary to enumerate the abnormities found in the stomach, liver, bowels, kidneys, etc. But the disease of alcoholism stands quite apart from these ailments. The patient may or may not have gastritis or enteritis or nephritis, but in all cases he will have an abnormal condition of the nervous system that produces either a perpetual or a periodic demand for the drug action of alcohol. Hence alcoholism *per se* is a disease of the nervous system. He who can drink moderately without ever becoming intoxicated may have the drinking habit, but he has not acquired the disease. This, however, does not prove that he possesses superior intelligence or will power. It only indicates that his nervous system is less susceptible than others to the poisonous action of alcohol. It is purely a physical difference that distinguishes the moderate drinker from the helpless drunkard. Professor Atwater's dictum that two ounces of alcohol a day is a food, and more than that a poison, may be true in some individuals. but as a statement of universal law it is absurdly false. I have a patient now under treatment to whom two ounces of alcohol is such an active poison as to transform him from a clear-headed business man into an irresponsible automaton.

The ætiology, symptoms and diagnosis of alcoholism are well known, but its treatment deserves far more attention than it has ever received. The advice given in some text-books appears to be of a purely theoretical character, unsupported by sufficient practical experience. Much of it is certainly very erroneous. In the acute stages, sleep and nourishment are of the first importance, especially if the patient has been on a protracted spree, or is showing signs of delirium tremens. If the stomach is too weak to retain more substantial food, an excellent aliment is hot malted milk. But the best food in this stage of the disease is eggnog, if the stomach will retain it, and it usually will. Beat up one egg in a tumbler, nearly fill the glass with milk, and add one or two ounces of whisky. Sugar may be added if desired, but sweets are usually distasteful to a patient in

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this condition. I believe this combination to be the *ne plus ultra* of foods in acute alcoholism. In many cases, however, the patient refuses all nutriment till after he has been made to sleep.

A very satisfactory hypnotic in this disease is a mixture of bromide of potassium and chloral in equal parts. This should be given in several small doses, the effect of each dose being carefully noted. Of the coal-tar products trional is the best hypnotic, but it must be given in large doses. Suggestion, as practised by the school of Nancy, is occasionally useful in promoting sleep. I never use morphine unless there is some unusual complication.

There is, however, one harmless remedy that will produce sleep in a few minntes, even when the patient is suffering with the wildest delirium. That remedy is apomorphine. I inject subcutaneously just enough to produce slight nausea, but not enough to cause vomiting. One-thirtieth of a grain is the average quantity required, but individual susceptibility to this drug greatly varies. In a few minutes after administering the remedy perspiration appears and the patient voluntarily lies down, when a sound and restful sleep immediately follows. This sleep lasts at least an hour or two. and, if other sedatives are previously given, it will usually last six or eight hours. The use of apomorphine in this manner and for this purpose is, I believe, original with me. While its value has remained so long unrecognized by the profession, yet in point of fact there is no hypnotic in our materia medica that is at once so prompt, so safe, and so sure. It is of special value in all forms of mania, regardless of the cause. It may also be given in full emetic doses in many cases of alcoholism with marked benefit. I have frequently had such patients express gratitude for the great relief afforded by this emetic. It seems to frequently act as almost a specific in relieving the alcoholic craving.

After the patient has recovered from the acute symptoms, he should have a course of tonic treatment covering a period of several weeks. The limits of this article will not permit a discussion of all the remedies that should be employed in the varying states of this erratic disease. An excellent one, if properly and judiciously used in connection with other remedies, is the nitrate of strychnine. It may be given, however, in much smaller doses than the text-books usually recommend. Potter, in his *Materia Medica*, advises the hypodermic use of this remedy. He says: 'It removes the craving for stimulants, counteracting the vasomotor paralysis, to which most of the injurious effects of alcohol are due, and is probably in other respects a true

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antagonist to the action of that narcotic poison on the human system."

Dr. Portugaloff, of Russia, under date of September 2, 1891, writes as follows: "I have first and foremost to state that the use of strychnine in the treatment of alcoholism is no discovery of mine. In all the articles I have ever written upon the subject I have always pointed out that the credit of the discovery belongs to the English and French doctors Luton and Dujardin Beaumetz. Convinced that all forms of drunkenness are but forms of disease, with perhaps a basis of vice, I have during the period of five years treated about five hundred patients suffering from different forms of alcoholism by hypodermic injections of strychnine . . . I do not order the patient at once to discontinue drinking. I prefer that he should voluntarily leave it off, and that alcohol should become distasteful to him. . . . Then I have cases of relapse—patients who once a year return to their old bad habits, but who, on such occasions, always come to me for a repetition of the treatment, which invariably sets them right again for another year. . . . I have always felt sure that if in obstinate cases the patient could be isolated, and all possibility of obtaining alcohol removed—which would be easy in a 'sanitarium for inebriates'—cure would certainly follow."

There are several reasons why the hypodermic method here recommended by Dr. Portugaloff and Dr. Potter is preferable to the administration of remedies exclusively by the mouth. The stomach is less burdened by drugs. The remedy goes directly into the circulation without being subjected to the action of the digestive fluids. The dosage can be regulated with great accuracy. The remedial action is more prompt. It brings the patient face to face with the physician several times a day.

It is remarkable how few physicians know how to properly give a hypodermic injection. It should not hurt nor scarcely be felt by the patient. It should never produce an abscess. It should not produce a temporary subcutaneous swelling. The operation should be performed so quickly that five can not be counted between the insertion and withdrawal of the needle. The physician who fails in any of these respects has not yet learned the art of administering a hypodermic injection.

As early as the sixteenth century gold was recommended as a remedy for alcoholism, and recently extraordinary virtue has been alleged for it. I have not, however, found that it possesses the marvellous properties attributed to it by the public, although it is probably not devoid of merit.

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One or more of the bitter tonics should be employed during the entire period of convalescence. With good appetite and digestion and restful sleep the patient will rapidly improve. The aim of the entire treatment should be to build up his general health, so that when he returns to his home he will be in the best possible condition.

Cheerful and hopeful surroundings, in the company of others who are under similar treatment, are conditions of great value. It is desirable that an earnest and purposeful spirit should be cultivated. It has been our custom for several years at our sanitarium here, in Boston, to begin each day with a simple service of songs and reading, lasting about ten minutes. I consider the *esprit de corps* of a properly regulated sanitarium is of great importance in the treatment of this disease.

The rescue of humanity from the physical, mental and moral ruin resulting from alcoholism and other drug addictions devolves not upon the moralist but upon the physician. This is the medical man's burden, and the enlightenment of the future will hold him responsible if he does not earnestly take it up.—*New York Medical Journal.*

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## THE TREATMENT OF ACUTE ARTICULAR RHEUMATISM AT THE MT. SINAI HOSPITAL, NEW YORK CITY.*

By L. A. S. BODINE, M. D., of New York City.

House Physician, Mt. Sinai Hospital.

In the following brief summary of the treatment employed for rheumatic cases in the Mt. Sinai Hospital, I have tried to adhere as closely as possible to rheumatism itself, and no make no mention of treatment used in any of the numerous rheumatic complications. In acute articular rheumatism, after a thorough clearing out of the alimentary canal with calomel and salts, our patients are at first put on sodium salicylate, from fifteen to twenty grains every four hours, with very frequently the addition of bicarbonate of sodium, the latter drug being given to render the urine alkaline and to maintain its alkalinity during the course of progress of the disease. Fluid diet, rest in bed, with sponge baths for hyperpyrexia at a temperature of from 95° to 75° F., depending upon the patient's condition, constitute the initial treatment

* Read before the Section on Practice of Medicine, New York Academy of Medicine, March 20, 1900.

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of these cases. If, for any reason, the salicylates are not well borne, owing to *tinnitus aurium*, eruptions or gastric disturbances, either the oil of wintergreen or the citrate or acetate of potassium is used as a substitute. In nephritic subjects neither the oil of wintergreen nor the salicylates are given. The bowels are kept open by cathartics, preferably salines and enemata. Hyperidrosis is controlled by doses of belladonna or its alkaloid. To control or relieve pain, phenacetin, acetanilid, antipyrin, and codein are used sometimes, but rarely morphine. To induce sleep, trional, in combination with the bromide of sodium, is a frequent remedy. Sometimes chloral, chloralose, cannabis indica, or even morphine itself is given. The diet during the acute stage consists of fluids only. Milk, strained soups, clam-broth, cocoa, egg-nogg, milk-shakes, ice-cream, lemon and orangeades satisfy the patient much better than does a pure milk diet, ane hence he takes his nourishment more willingly and frequently. Coffee in small quantities is also given, but if often taken is apt to cause insomnia. Nitrogenous food is avoided as much as possible, and large quantities of water are taken daily. The salicylates are always given well diluted, and never, if it can be avoided, on an empty stomach.

Local applications of oleum gaultheriæ, salicylate of menthol, or guaiacol painted over the inflamed joints, and rubber protective bandaged firmly over them, seem to afford great relief to the majority of patients, and also to exert a favorable influence on the inflammation. When a joint involvement passes the ordinary inflammatory stage and there is a commencing effusion, local applications of tincture of iodine, uniform pressure by bandaging, cold in the form of ice-bags, immobilization, and elevation of the joint, if possible, are successfully used to abort and inhibit the exudation. In spite of treatment the effusion may persist, and with it some elevation of temperature. In these cases the joint itself is aspirated in order to determine the character of the exudate. If pus or purulent serum is found, the case becomes a surgical one, and is treated accordingly. In those cases in which the effused fluid is absorbed and there is a disappearance of all of the constitutional symptoms, there may still remain pain on motion, some periarticular thickening, and more or less anchylosis. In these cases local treatment seems to give the best results, and is the only treatment used, except the internal administration of the iodidle of potassium. For local treatment we use daily baths of hot air at a temperature of 200° F. 400° F. for from twenty minutes to a half hour duration, hot salt-packs, hot sand-bags, local applications of iodine, galvanism, cataphoresis, passive motion, and massage.

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In the majority of instances iodide of potassium internally, combined with passive motion, massage and the hot-air bath have given the best results. What gives good results in one case does not always do so in another; so we may have to try a number of remedies before finding one suited to the case in question.

Before the convalescent stage, particularly if the attack has lasted for any length of time, tonic treatment is instituted, most frequently in the form of iron, strychnine, and quinine. The salicylate of iron is another remedy often employed. After the temperature has remained at the normal point for from forty-eight to seventy-two hours the diet consists of eggs, bread, potatoes, toast, and fresh vegetables, but no meats. In some cases in which the fever persists and the patient seems to be suffering from malnutrition, it may not only be advisable, but necessary, to enforce such a diet at an early date. Meats are withheld until convalescence is well established, and are first given in the form of chicken or turkey. Absolute rest for all cases of pyrexia is required, and all patients are kept in bed for from two to five days after their temperatures have reached the normal point.

Out of thirty-eight cases of acute articular rheumatism treated in this hospital during the past year, twenty-nine left the hospital cured, and nine were discharged improved. Of these thirty-eight patients all but three had had salicylic acid in some form or other.—*Interstate Medical Journal.*

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# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine University of Bishop's College; Physician Western Hospital.

### THE USE OF COLD IN THE TREATMENT OF PNEUMONIA.

[EDITORIAL NOTE.—The following question was addressed to a selected list of representative clinicians in various parts of the United States:—"Has the application of cold given you satisfaction in the treatment of pneumonia?" The replies came in very speedily, and the assembled opinions not only form a mass of strong testimony, but have also, as the *Journal* desired, much of the force and freshness of speech.]

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A partial analysis of the testimony, made, as nearly as possible in accordance with the language of the writers' gives the following results:

The therapeutic use of cold in lobar pneumonia is—

*Very valuable*, according to seven observers: Baruch, Folsom, Fowler, Mays, Musser, Stucky, Wilson;

*Valuable*, according to nine observers: Atkinson, Bowditch, Cutler, Forcheimer, Johnston, Lange, Rochester, Stockton, Tyson;

*Useful*, according to four observers: Fitz, Hare, Janeway, Smith;

*Unsatisfactory*, and abandoned, one observer: Eichberg.

MODE OF EMPLOYMENT.

*Ice bags*, by thirteen observers. Those who do not recommend ice bags are Baruch, Bowditch, Fitz, Folsom, Fowler, Janeway, Johnston;

*Cold wet compresses* are approved by seven observers: Baruch, Cutler, Folsom, Fowler, Johnston, Musser, Stockton;

*Cold sponging*, five observers: Atkinson, Bowditch, Fitz, Musser, Stockton;

*Cold plunge or tub*, six observers: Atkinson, Folsom, Musser, Rochester, Stockton, Wilson;

*The cold sheet* is applied to the front of the body by Janeway.

INDICATIONS.

*Hyperpyrexia* is the only symptom relieved by cold, according to Janeway, Smith and Tyson;

*Pain and delirium* are also relieved, according to Atkinson, Baruch, Bowditch, Cutler, Fitz, Folsom, Forcheimer, Fowler, Johnston, Mays, Musser, Rochester, Stockton;

*The heart and lungs* obtain relief from mechanical embarrassment, in the opinions of Baruch, Cutler, Fowler, Hare, Lange, Mays, Musser;

*The toxemia* is lessened, according to Baruch and Musser.

CONTRAINDICATIONS.

As to contraindications, Musser says that they are precisely such as are recognized in typhoid fever. Atkinson, Bowditch, Cutler, Folsom, Smith and Tyson admit practically the same contraindications. Forcheimer warns against the use of ice bags in children. Janeway says that furunculosis may follow the application of cold to the posterior chest. Lange considers marked toxemia a contraindication.

*Broncho-pneumonia* is mentioned by Forcheimer, Hare, Lange, Rochester, as unlikely to be benefited by cold. Mays employs ice bags in catarrhal pneumonia. The good effects

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of warm moist applications in this class of cases, especially in children, are spoken of by Forcheimer, Rochester and Smith.

PERIODS OF EMPLOYMENT.

On this point Stucky advises cold applications from the moment of diagnosis until "resolution is well established." Cutler says that the indications for the use of cold "do not extend beyond a few days, perhaps only over a few hours." Baruch, Bowditch, Folssom, Fowler, Mays, Musser, Rochester and Tyson use cold through the period of pyrexia. Fowler mentions 104° and over as the thermometric indication for cold applications. Tyson applies ice as often as the temperature goes above 104°.

*Eichberg* alone of the twenty clinicians has abandoned cold applications, having found them unsatisfactory. He uses hot baths in all but anemic or very prostrated patients.

The collected testimony seems to assign to hydrotherapy a very important place in the treatment of lobar pneumonia, and these short utterances, coming as they do from authoritative sources, form a substantial contribution to practical therapeutics.—*Maryland Medical Journal.*

Dr. Andrew H. Smith, in the *Medical News* of December 16, advocates the use of creasote in the treatment of pneumonia. He believes that pneumonia could be prevented if persons known to be susceptible would always begin at once to take full doses of creasote on the appearance of those symptoms which are popularly described in the phrase "taking cold".

His use of this remedy is based upon his very interesting views upon the pathology of pneumonia. He lays especial stress upon the double circulation in the lung, that from the left heart, borne in the nutrient vessels, and maintaining its integrity during the whole course of pneumonia, and that from the right heart which becomes thrombotic throughout the affected area.

This arrangement of closely adjacent double circulating channels removes pneumonia, he says, "out of the category of diseases for which analogous conditions can be found in other parts of the body." The pneumococcus is the essential pathologic factor, but it does not excite inflammation, the elements of perverted nutrition, necrosis, interstitial deposits, obliteration of vessels and new formations being absent. The process, he says, is a germ culture going on in each air-cell, as in a tiny test tube, on a special medium supplied by the functional blood-vessels. This bacterial growth is the essence

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of the pathology of pneumonia, and the mechanical and chemical results are but more or less serious epiphenomena. The extent of the bacterial growth is limited, partly by exhaustion of the medium, partly by the formation of pneumic acid, inhibiting growth, and partly by the development of an antitoxin. Crisis occurs promptly upon the arrest of growth of the pneumococcus, because the nutrient vessels permeating the consolidated area, but not participating in or suffering from the disease process, are ready at once to assist in removing the exudate and restoring the functional blood channels.

From this central idea that "the beginning of pneumonia is the lodgment of the pneumococcus in the air-cell" he reasons that the symptoms and signs upon which we ordinarily base the diagnosis of pneumonia really indicate a very advanced stage of the disorder. Antimicrobic treatment is nevertheless valuable, since it is possible to charge the blood with a substance which, being borne to the margins of the consolidated area, will prevent the further growth of the bacillus. Besides its accessible situation in the lung, he considers the known cultural peculiarities of the pneumococcus, its brief existence under laboratory methods, and its sensitiveness to acids. He cites the successes in the treatment of pneumonia claimed by various authors for calomel, chloroform, the salicylates, and creasote.

Of these, Smith strongly prefers creasote in the form of the carbonate creasotal. He takes occasion to condemn the use of digitalis in those cases marked by cyanosis and dilated veins, where life is threatened chiefly by the mechanical obstruction. He says that in his experience "blueness and digitalis go hand in hand."

His remarks upon accessory treatment are very brief, comprising, first, stimulation of the emunctories; second, sustaining the heart by stimulation and hydrotherapy; third, relieving the pulmonary condition by vaso-dilators or venesection; fourth, compensating loss of respiratory surface by inhalations of oxygen; fifth, reduction of excessive temperature by cold applications.—*Maryland Medical Journal.*

## TREATMENT OF INSOMNIA.

In the treatment of habitual sleeplessness there are two main factors: The removal of the cause and breaking up the the habit. When acid or gouty dyspepsia is the cause, says J. B. Bradbury (quoted in *Monthly Cyclopedia of Practical Medicine*), it is essential to avoid tea, fruit and vegetable acids. An alkaline bitter before meals and an occasional mercurial at bedtime, followed by a saline aperient the next

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morning, are of service, and in the gouty, colchicum and magnesia or sodium salcylate should be prescribed. Nux vomica and strychnine are good remedies for the insomnia of age and fatigue and cardiac and vascular disease. Digitalis and other cardiac tonics are indicated at times in cardiac disease and neurasthenia with low arterial tension. For anemia, iron, nux vomica and sometimes digitalis are required. Sleeplessness from overwork and worry demands mental rest and change of air and scene. Capsules containing 30 minims of turpentine, taken at bedtime, are occasionally beneficial in these cases. No beverages containing caffeine should be drunk after breakfast. The cool air bath or wet pack or bath is often decidedly sedative, as is a glass of whiskey and water, to those unaccustomed to alcohol. The bromides are very useful in nervous and hysterical women, and a mixture of a bromide with tincture of sumbul and tincture of hops in camphor water is serviceable at the climacteric.

Concerning the habit of sleeplessness, it is here that hypnotics are of great value, the bromides being the least harmful (30 or 40 grains dose), though sulphonal (20 grains) and paraldehyde are in the front rank for effectiveness. If possible the bedroom ought to be in a quiet part of the house, well ventilated, of moderate temperature, scantily furnished and darkened. For young and middle-age adults a firm mattress is the best bed, but the old may require something softer. The covering should be light and warm. The pillows may be arranged according to individual choice. As a rule, a light supper is best, and for many, especially those who awake in the middle of the night, a little hot milk or meat juice with a small amount of alcohol is helpful. If the feet are cold, rub them vigorously or use the hot bottle or the foot-bath with mustard. Massage is sometimes advantageous, and may be aided by a hot compress to the abdomen. Walking about naked or taking a cold or tepid bath is also often of service.

## PAINTING WITH FORMALIN IN THE SWEATING OF PHTHISIS.

Dr. H. Hirschfield (*Medical Press and Circular*, April 11, 1900) covers the patient with a coat of formalin, protecting the nostrils with plugs of lint soaked in turpentine. In this way no harm is done to the respiratory organs. In the 100 cases treated by Dr. Hirchfield there were no failures, although one-half of the cases were such as had derived no benefit from antihydrotics. In some cases a single painting

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was sufficient to prevent a return of the sweating for some weeks. Others required two applications, and in three the painting had to be done three times before a lasting success was effected. No physical effect was produced on the skin except a slight scaliness, and in one case a mild urticaria and slight erosions.

## INFANTILE COLIC.

It is one of the commonest ailments in infancy, and frequently appears in those perfectly well in other respects. It may occur either only occasionally or many times every day. The symptoms consist of sudden and violent crying—which may continue until the child is bluish in the face and often exhausted and cold—a swollen and hard abdomen, and doubling up and straightening of the legs, arms and trunk. These symptoms last a variable time and then suddenly cease, perhaps preceded by the passage of wind by the mouth or bowel. Chilling of the skin and indigestion are the commonest causes, the latter usually depending on too frequent or too abundant feeding. To prevent repeated attacks the stomach should be allowed to rest by diminishing the amount of nourishment and increasing the length of time between feedings. If the baby is bottle fed, it may be necessary to change the character of the food in some way, but this should be the duty of the physician. The child must be warmly clothed, since any chilling of the surface may cause pain, no matter how good the digestion may be. The feet and legs especially should be kept warm by thick loose stockings and by daily friction with a mixture of 1 part of turpentine and 3 parts of sweet oil. An abdominal binder may be worn if one is not already in use.

During an attack the baby must never be fed. The warm milk, it is true, often stops the crying for the moment, but it is sure to increase the indigestion and to bring the pain back as bad as or worse than ever. Rubbing the abdomen for several minutes, or the mere change of the child's position, as by lifting it over the shoulder, will sometimes cause the gas to escape and the colic to cease. A spice plaster is often very useful. It is prepared as follows: Take 1 part each of ground ginger, cloves, cinnamon, and allspice, with or without ¼ part of cayenne pepper, according as the plaster is to be strong or weak. Put the dry and well-mixed powder into a flannel bag, spread it evenly and quilt the bag to prevent the spices from getting into lumps. Before applying, wet it with hot alcohol or hot whiskey. The same

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# SURGERY.

IN CHARGE OF

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AND

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## TO IRRIGATE OR NOT TO IRRIGATE IN INFLAMMATION OF THE PERITONEUM AND AFTER ABDOMINAL OPERATIONS.

There is still a wide diversity of opinion among surgeons as to the value of irrigation after surgical operations and in inflammation of the peritoneum. Many operators believe that intra-abdominal work should follow the same rules that are applied to surgery on external surfaces. The peritoneum is surgically regarded in the same light as the skin, they both having epithelial coverings. Incisions into the peritoneum are to follow the same rule as incisions into the skin, and after the removal of organs or plastic work within the abdomen the incisions are covered in by this membrane, which is to be carefully sutured. With an aseptic technique and field, such a conception of abdominal surgery is an ideal one. An operation which leaves carefully approximated peritoneal surfaces and the abdomen perfectly dry at the time of the closure of the external wound, leaves nothing to be desired in the aid of the healing process.

The conditions that confront a surgeon in a septic case, or one in which the inflammation has extended to the peritoneal surfaces, are quite different. Here the question of irrigation is still *sub judice*. Many operators are of the opinion that, if the infection is of sufficient severity to have extensively involved the peritoneum, irrigation will be of no value, and, on the contrary, may do harm by diluting and spreading the infection to previously uninvolved portions of the peritoneum, and may actually aid in the absorption of toxins from the peritoneal cavity. Other equally good operators are of the opinion that irrigation does get rid to a certain extent of the infecting agent and ptomaines, and the products of bacterial growth are washed out of the abdomen.

Unfortunately, the question is one to be decided largely

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by the experience and opinions of individual operators, as it seems almost impossible to study it from an experimental basis, and the examination of statistics presents so many extraneous and accidental conditions that figures based upon these alone are exceedingly fallacious. So far as conclusions may be drawn from the published cases, we feel safe in asserting that aseptic operations should be conducted without flushing and without drainage. In those in which there is a general infection of the peritoneum from a suppurating focus, or in which the operation is made for the purpose of relieving septic peritonitis, it is probable that flushing and drainage is a material aid in the recovery of the patient. The flushing, if done at all, should be thorough; that is, in a widespread septic peritonitis, if it is to be of any value, it must not consist of the pouring of a few quarts of water into the abdominal cavity and allowing it to drain away, but it should be done with many gallons of aseptic normal salt solution. There are now a number of cases on record in which some form of continuous irrigation has been employed with success. There is great need of further studies along these lines, as the treatment of septic peritonitis from the operative standpoint does not form a brilliant chapter in the mortality records.—*Medicine.*

## DRAINAGE.

Paul Morf, in the *Bulletin of the Northwestern University Medical School*, of January 31, 1900, says that wounds may be divided with reference to drainage into two classes: First, those which are aseptic; secondly, those which have been infected, or are made to relieve suppurative conditions. In the vast majority of cases drainage is unnecessary in aseptic wounds. The danger of drainage is due to the fact that the skin contains normally germs which cannot be wholly removed. The drain, whether capillary or tubular, moistened by secretions, is a ready pathway for the entrance of such infection from the surface to the deeper structures. Aseptic wounds in which no antiseptics have been used have, as a rule, little oozing. Healthy tissue can take care of a large amount of extravasated blood and lymph. Drainage in aseptic cases is limited to those cases where there has been much traumatism, and where large areas of lymphatic vessels have been opened. Examples of this class of wounds are furnished by amputations of the breast with their attendant dissection of the axilla, amputations of the thigh and hip, and extirpations of tubercular lymphatic glands. Another class of cases is where there remain "dead spaces" which

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cannot be obliterated by deep sutures or other means. Examples of these are furnished by unilateral thyroidectomy and operation for carcinoma of the rectum. In most of these cases twenty-four hours is a sufficient time to leave the drain in position. At the end of that time the tissues have accommodated themselves and the dead spaces are obliterated.

In infected wounds and those made for the relief of septic foci, drainage is demanded almost without exception. Drainage of abscess empyemas and suppurating joints should be made in the location which gives the best possible escape to the secretions. A good-sized fenestrated rubber tube is to be preferred, which, if possible, is to be carried through the cavity and out at a counter-opening. As the suppuration lessens, this is to be replaced by a drain of iodoform gauze.

In the relation of drainage to the abdominal cavity it is difficult to make a general statement, but drainage is useful when pus is found free in the peritoneal cavity, as in cases of acute suppurative peritonitis; where there is localized pus formation, the suppuration being walled off by adhesions—this class of cases includes appendicular abscess, pelvic disease and pus tubes. Drainage must also be employed in the removal of pus from a hollow viscus.—*Medicine.*

## LOOK TO THE TEETH.

Dr. Howard B. Hills, of Youngstown, gave the following hint anent eye diseases:

Mrs. B. W. called at my office for relief from an exceedingly troublesome eye. The e was pain, lachrymation, photophobia and congestion. After the examination I directed her to her dentist, who extracted a wisdom tooth in the right side of her jaw. Within a week she returned to tell me her eye had not troubled her after the tooth was out.

Mr. D. J. was directed to my office by one of our local physicians, because of an intense photophobia and lachrymation of both eyes. I sent him, in turn, to his dentist, who extracted all his imperfect teeth, and within ten days his eyes were free from pain, and as clear and bright as they had ever been. These cases will, I think, answer the purpose I had in writing this brief paper. I have in my case book the history of a case where the filling of a molar tooth promptly stopped an earache. In conclusion I will add that, while we know all these things, our business and interests demand that we should not forget them.

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## TREATMENT OF ORCHITIS.

Dr. Pigot highly recommends the following treatment for orchitis due to gonorrhea: The patient is first given an ounce of salts as a purgative and then salicylate of soda, fifteen grains, four times a day. Improvement shows itself after twenty-four hours, and at the end of eight or ten days the cure is complete. Mercurial ointment need only be employed where there is effusion into the vaginal sac. During the treatment the patient remains in bed, and maintains constantly *in situ* a suspensory bandage lined with cotton wadding.—*Paris Cor. Med. Press and Circular.*

## CHRONIC ECZEMA.

A *confrère* asserts that he obtains the radical cure of eczema where it occurs in isolated patches on the upper extremities and so rebellious to the ordinary method of treatment, as follows: After having washed thoroughly with soap and water the part and dried it, he rubs in vigorously a fifty per cent. solution of caustic potash by means of a plug of cotton tied to a rod; he then washes the spot freely with water, and, finally, paints it over with a fifty per cent. solution of nitrate of silver, and envelops the whole in aseptic cotton. This pressing is left in place until the cicatrix is formed beneath the slough, or from one to two weeks. The itching ceases immmedialy after the application of the caustics. Out of thirty cases thus treated, only one required the operation a secord time.—*Med. Press and Circular.*

## BOILS.

Not long ago I was afflicted with a developing boil on the back of my neck. I was kept painfully conscious of its presence and tenderness by the constant rubbing of my collar. I chanced into a neighboring doctor's office and incidentally referred to the annoyance of the aforesaid boil, and wished he could stopped its progress. The good doctor examined it and said aqua calcis will do it. I questioned the taking of lime water for such a complaint, but he advised taking a teaspoonful three or four times a day. Three or four doses settled the boil.

The conversation regarding the boil brought forth another statement from the same good doctor, and that was that the suppuration in tonsilitis need never occur if treated with aconite tincture and phytolacca tincture in fractional drop doses in alternation every hour or two. The same may be said of inflammation of the mammary glands.—*Med. Arena.*

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# OBSTETRICS.

IN CHARGE OF

H. L. REDDY, M.D., L. R. C. P., London,

Professor of Obstetrics, University of Bishop's College; Physician Accoucheur Women's Hospital; Physician to the Western Hospital.

## INFLUENCE OF PREGNANCY UPON THE TEETH.

Terrier states that caries is more rapid in its advanc that the sensibility and friability of the teeth are increase that their chemical composition is altered during pregnancy. These changes are caused by gingivitis of pregnancy, alteration of saliva, acid regurgitations from the stomach, general modifications in the digestive and in the urinary apparatus and increased excitability of the nervous system due to pregnancy. He urges careful cleansing of the teeth and treatment of caries and gingivitis early in pregnancy, while the daily care of the teeth should be continued through pregnancy and lactation.—*Jour. Obstet.*

## HYPEREMESIS GRAVIDARUM.

Dirmoser believes that auto-infection from the intestinal tract is the usual cause of hyperemesis, and that the etiological importance of hysteria is largely overestimated. He refers to the similarity of postmortem changes in hyperemesis and acute infection. Urinary analysis shows an increase of indol, skatol and other products of retrograde metabolism, also albumin, acetone and peptone. Organic structural elements are found in the urine, indicating a nephritis. There exists an individual predisposition, probably owing to the abnormal condition of the intestinal canal. The best treatment for this obstinate and often serious complication of the pregnant state would be intestinal antisepsis, and the author states that the results obtained from such treatment will be published at a later date.—*Jour. Obstet.*

## INDUCTION OF LABOR FOR NEPHRITIS.

I. W. Lwoff writes that cases of so-called kidney of pregnancy may sometimes be carried to term by milk diet, baths and pilocarpine, but when the albumin increases and urine diminishes induction of premature labor is indicated. These accidents usually begin about the sixth month and pregnancy may be carried to the second half of the eighth month before inducing labor. In cases of acute nephritis

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gestation should be interrupted at once whatever its duration may have been.

In chronic nephritis interference with pregnancy is demanded whenever the general condition becomes worse.

### PUERPERAL INFECTION.

H. W. Longyear states that the early diagnosis and treatment of pseudo-membrane by topical applications is of great importance.

The intra-uterine douche frequently applied is of the most value in the forms of infection unattended by the formation of a pseudo-membrane. The vaginal use of peroxide of hydrogen is helpful in all forms of infection. Frequent packing of the vagina previously dried with iodoform gauze is especially useful in cases with pseudo-membrane. In the general treatment he gives quinine twice daily, whiskey and strychnine to support the heart, nuclein and protonuclein in all cases, mercurial and saline cathartics at first in all cases, then as indicated. Serum therapy to be applied where the Klebs-Loffler bacillus or the streptococcus can be demonstrated by the bacteriologic examination. Stretococcus antitoxin serum is to be used persistently to prevent pus formation and symptoms of systemetic infction.

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# Therapeutic Notes.

### MUSCULAR RHEUMATISM.

℞ Sodii salicylatis.
Potass. acetatis aa..... dr. 4
Glycerini..... oz. 2
Acquæ q. s. ad..... oz. 4

M. Sig. One teaspoonful in one-half glass of water or milk every two hours.—*Ex.*

### CHILDREN'S EMETIC.

℞ Pulv. ipecacuan..... gr. viiss
Antimonii et potassi tartratis..... gr. ⅙
Oxymel scillæ..... ʒiiss
Aq. distill. q. s. ad..... ℥i

M. S. One teaspoonful every ten minutes.—*Baginsky*

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INHALATION IN TUBERCULOUS LARYNGITIS.

℞ Menthol.
Ether. sulphuric.
Ol. pini sylvestris.
Tinct. iodi aa..... ʒij
Tinct. benzoin. co. ad..... ʒij

M. S. Ten drops on an oro-nasal inhaler which is worn as much of the time as possible.—*W. Fowler.*

TREATMENT OF BALDNESS.

Dr. Whitla gives this as one of the best combinations in the treatment of baldness:

| | | |
|---|---|---|
| ℞ | Pilocarp. hydrochloratis..... | gr. 5 |
| | Otto rosæ..... | m. 8 |
| | Ol. rosmarini..... | dr. 4 |
| | Linimenti cantharidis..... | dr. 4 |
| | Glycerini puri..... | oz. 1 |
| | Ol. amygdalæ dulcis..... | oz. 3 |
| | Spts. Camphoræ..... | oz. 3 |

M. Sig. To be rubbed well into the scalf night and morning.—*Ex.*

PNEUMONIA.

Bowen, in his late work on *materia medica*, prescribes for pneumonia:

| | | |
|---|---|---|
| ℞ | Ammonii iodidi..... | 2 drachms |
| | Spir. ammon. aromatic, fl ..... | 2 drachms |
| | Elixir, simplicis, fl ..... | 1 ounce |
| | Aquæ q. s. ad., fl..... | 8 ounces |

M. Sig. Two tablespoonfuls three times a day.—*Prescription.*

A GOITRE REMEDY.

Dr. Chavette, who will be remembered by the older Chicago physicians, claimed to cure every case of goitre he treated by the use of the following remedy:

| | | |
|---|---|---|
| ℞ | Zinc sulphate..... | 2 drachms |
| | Salicylic acid..... | 2 drachms |
| | Iodoform ..... | 2 drachms |
| | Boric acid ..... | 3 drachms |
| | Oleic acid..... | 8 ounces |

Mix and keep at a boiling heat for several hours, then pour off the liquid, and when cold, bottle. Sig. Apply to the enlarged gland, with slight friction, twice daily, until a slight desquamation occurs, after which apply once daily until the enlargement is entirely reduced. In no instance did the disease return.—*Medical Council.*

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FISSURE OF NIPPLES.

℞ Tinct. benzoini compositæ.... 2 drachms
Listerinæ ..... 4 drachms
Aquæ camphoræ q. s. ad..... 3 ounces

M. Sig. Shake. Bathe nipple, and apply freely after each nursing.

A CURE FOR RINGWORM.

℞ Salicylic acid..... gr. viij
Vaselin ..... dr. j

Mix and apply twice daily. Sometimes a little stronger salve is necessary.

TREATMENT OF HEMORRHOIDS.

Dr. J. P. Tuttle, in a recent lecture at the New York Polyclinic, said: In cases of internal hemorrhoids that are thought suited to cure by the injection method, I use the following formula:

℞ Carbolic acid..... 1½ drachms
Salicylic acid..... 1½ drachms
Soda biborate..... 1 drachm
Glycerine(sterilized),q.s. ad. 1 ounce

M. ft. liquor. Sig. Inject for hemorrhoids.

Of this fluid from two to four minims are injected into the base of the hemorrhoid If other injections are to be made, they are made in from three to five days.—*Polyclinic.*

CHILDREN'S SORE MOUTH.

Borax..... 2 drachms.
Tinct. Benzoin..... 1 drachm.
Honey..... 10 drachms.
Aq. Dest... .....q. s.ad..... 2 ounces.

Dip a camel's hair brush into this solution, and touch patches in mouth four or five times a day.—*N. Y. Med. Jour*

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# Jottings.

## HEART DISEASE IN CHILDREN.

Dr. Weill (*Therapeutic Gazette*) states that in the treatment of heart diseases, in children if marked insomnia exists, it should be combated with Trional or Sulfonal.—*Archives of Pediatrics*, January, 1900.

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## TO REMOVE WRINKLES.

Oil of sweet almond, two drachms; cacao butter, four drachms; lanolin, two ounces; glycerine, two drachms; otto of rose, two drops. Melt the three first ingredients, then add the other two, according to "Practitioner." It is applied at night. Another useful application is Glycerole of tannin, rosewater, of each one drachm. Mix. To be applied to the wrinkled surface with a camel's hair brush.

## ACUTE BRONCHITIS.

According to the *Indian Med. Rec.*, the most painful period in acute or subacute bronchitis is at the onset, when the expectoration is absent and the cough very severe. According to Dr. F. Edgeworth, of Bristol, caffeine, especially when associated with an alkali, facilitates the expulsion of the sputum and shortens the stage. He employs every three or four hours a dose of from fifteen to twenty-five grains of citrate or acetate of potassium, and in addition at bedtime five grains of caffeine. Administered in this way he finds that caffeine quickly overcomes the spasm of the bronchial muscles, which checks the expulsion of the sputum and thus relieves the patient.

## HOW TO GIVE A HYPODERMIC INJECTION.

This is a simple procedure which, however, may be the making or unmaking of the doctor. It is so common to give it the wrong way, the most painful way, as much so, nearly, as it is not to feel the stab of the needle if one is not receiving it. The wrong way is to pinch up a fold of skin in the tenderest part of the upper limb, the anterior fore-arm, and then slowly push the needle through, shoulderwards, with as much deliberation as if it was intended to make it steal to its destination without cognition by the involved nerves. We never see it done this way without imagining part of the unnecessary pain it causes, and having rather hard feelings against the introducer of the needle.

The right way to do this is to pick up the entire fleshy mass between the skin and the bone in the less tender part of the upper limb, the back upper arm or shoulder, and push the needle directly through at right angles to the skin. It should be done with a quick stab, and made to enter the muscle mass. The fluid is then gradually pushed home, after which the needle is withdrawn quicker than it went in, the puncture site being massaged for a moment for the double purpose of obliterating the needle track and promoting absorption of the injected liquid.

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Try this method once and you will never want to go back to the other. The patient does not mind it. We have never had an abscess in twenty years' work. It is the only right and least painful way of giving a hypodermic injection. —*Med. Council.*

## GOITRE OINTMENT.

An ointment made by incorporating ten grains red iodide of mercury and one-half grain atropine with one ounce of some unguent is a useful external application in goitre; a piece the size of a pea, or slightly larger, to be well rubbed into the skin over the tumor two or three mornings in succession, and repeated once a week. This, with iodides of mercury and arsenic internally, was the treatment used by an old Scotch physician, who made a reputation and a fortune with it.—*Alkaloidal Clinic.*

## GOLDEN RULES OF OBSTETRIC PRACTICE.

Do not be unduly hopeful if a tubercular patient seems to improve during pregnancy. She will probably lose ground rapidly when gestation is ended.

Improvement in the later manifestations of syphilis is often observed during pregnancy. But it does not indicate that treatment may be neglected.

If albumen appears in the urine for the first time during pregnancy, be prepared for eclampsia. Where chronic renal disease is known to exist there need be less fear of this complication, though the disease is aggravated by pregnancy.—*Fothergill.*

## THE HOT DRY-AIR TREATMENT OF RHEUMATISM.

An editorial in the *International Medical Annual* criticises this revival of a method as being generally useless and harmful in regard to permanent effects. The excessive or long-continued application of dry heat, he says, tends to destroy the functional activity of the skin, and impairs the nervous mechanism of the joints. A more simple, convenient, comfortable and efficient application of local heat than can be made by any of the patented appliances is as follows: Six thicknesses of flannel of convenient size are sewn together; these are wrung out of water at 120° F., and wrapped around the joint over this is placed a hot-water bottle filled with water, and the whole secured with a flannel wrapper.

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THE
# CANADA MEDICAL RECORD
PUBLISHED MONTHLY.

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## Editorial.

The surgical history of the present war in South Africa has been a series of surprises, and the unexpected has been constantly occurring. In this connection it is a matter of very great interest to look back to the introduction of the rifle now in use as the weapon of the British Army. At that time there was much speculation as to the terrible execution it would make. There was also a distinct recognition by more than one observer of the special conditions in which the wounded would be placed, because of the great distance the bullet is carried. Professor Bilroth, in 1891, writing of the new rifle adopted by the Austrian Army, said: "Every new gun carries further and wounds at greater distance than its predecessors . . . . and this means that the shelters for the wounded have to be set up at greater distances from the line of battle . . . . Thus all ambulance duty to be effective should be proportionately increased." About the same time Surgeon Captain Perry Marsh, of our own Army, lectured before the United Service Institute on the new "Magazine Rifle in War." In his lecture he said: "From the increased range, lower trajectory and more rapid firing power of the new rifle, the number of wounded will doubtless, in every conflict where these weapons are used, be very large, and much exceed the average of what was obtained in battles up to the present date." Commenting on this extract the

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*British Medical Journal* of Jan. 16, 1892, says: "These speculations, based on no doubtful data, suggest the practical question, Are the numbers and equipment of our bearer companies and field hospitals keeping pace with the demands which the new warfare will make on them. Alluding to the nature and treatment which the new gun shot wounds will demand, Marsh says: "The treatment of the wounded should begin in the field at the earliest possible time after the injuries have been received." Again, "What is most likely to be felt in future campaigns will be the want of moving hospitals, where the entire treatment of a large proportion of the wounded may be carried out." Again, "For future campaigns the number of bearer companies allowed to each Army Corps, and the strength of each individual company, will require considerable augmentation if we wish to provide for the increased requirements which may reasonably be expected in future campaigns." This same writer proves, not only theoretically, but from practical experience from accidents, that the fear of the deadliest results from this rifle, as prognosed by Bilroth, was not correct. He found that the direct injury and concomitant shock was much less than from the bullets of the older Snider and Martini-Henry rifles. This he believed was due to three factors: the material comprising the projectile, its lessened diameter and increased velocity. The *British Medical Journal*, reviewing the theories as advanced by Marsh, uses these words, which may truly be said to have been prophetic, when one considers the experience of the present South African War, "The outlook for injuries by these new weapons is not, therefore, so terrible after all. The assumption is warranted that many men in future wounded by small arms will only be temporarily disabled, and if promptly and properly treated would soon be in the ranks again."

These are very striking statements written some years before any experience on a large scale had occurred. One point, however, which will demand the strictest investigation by the committee appointed, as a result of the charges made by Mr. Burdett-Coutts, is this: Whether in view of the statements made by Marsh there has been since his lecture any

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marked increase in the number of bearer companies or in their strength. If there has not, the War Department will certainly come in for considerable blame. If we are to judge from the statements which have from time to time appeared in *British Medical Journals*, there is no doubt that the Royal Army Medical Corps has been numerically absolutely unable to cope with the army Britain sent to South Africa. This is proved by the fact that fully four hundred civilian surgeons are employed at the seat of war, and that the numerous private field hospitals, which private munificence organized, have had more than an abundance of work to perform. Military men say that civilian surgeons are the curse of any army. Utterly unacquainted with the details of military life, which are so essential to make things run smoothly, they get them so tangled as to make their straightening out well nigh an impossibility. This has occurred again and again in South Africa. Dr. Conan Doyle, writing from the seat of war, says that the authorities have been vainly trying to meet the necessities of over 200,000 men from the regular medical establishment sufficient only for two Army Corps or less than 80,000 men. It is as much the duty of the War Office to provide sufficient medical establishments for peace and war as to organize sufficient transport or artillery. While we condemn, as a rule, the employment of untrained civilian doctors in a military capacity, it is but right to admit that, had it not been for them, the medical arrangements of the present campaign would have collapsed long ago.

## COLLEGE OF PHYSICIANS AND SURGEONS, PROVINCE OF QUEBEC.

The half-yearly meeting of this College held in the early part of this month was perhaps the most remarkable of which the history of the College has any record. The work of the Credential Committee doubtless hid this fact from the knowledge of the governors, and thus certainly saved a great deal of useless discussion. This Committee for a day of three sessions and a day of one session held a reception, when, figuratively speaking, the blind, the lame and the distressed, came before them and pleaded that either the Pinault

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amendment of 1898 or the Roy amendment of 1900 applied to their particular case. As a general rule, it was very often hard to say that they did not, and as a consequence the Committee felt that a general amnesty all round was in order, and acted accordingly. Any one with a ghost of a show was not turned away empty handed. Those who did not have this show were honest enough not to complain. They admitted that they were the most irregular of the irregulars, and left determined to improve matters before the meeting at Quebec in September.

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It has already been a mystery to us how many irregulars—that is irregular in their manner of entering the profession—have for years appeared before this Licensing Board. It can only be accounted for by the fact that the Credential Committee has almost every year—certainly every three years—altered its decision in previously similar cases. As a consequence, no officer of the College felt justified in saying what action this Committee would take in any case presented to it. This fact becoming known, possibly justified students in hoping that when their turn came the action of the Credential Committee might be in their favor. The plea so often set up in the past and even to-day that such and such rules were unknown to them, is absurd. If unknown it is because they do not take the trouble to learn what it was their duty to know.

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The present Credential Committee is suffering to a large extent from the faults of its predecessors, whose decisions we have no hesitation in saying were often absurd and irksome. The consequence is that, in the Legislature of the Province, the College has lost many friends, and the students found not a few. The situation is in our opinion somewhat critical. If care is not taken, the College may be deprived of many of the safeguards which it is necessary it should possess, and which have largely elevated the profession. But there is no need to be oppressive. We think the preliminary examination of the Board is perhaps too apt to be considered as a means of keeping men out of the profession than of permitting them to enter it. If not, then but one conclu-

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sion can be arrived at, viz: that it is not on a line with the ordinary education given at the numerous educational institutions of the province. In this way only can the really enormous proportion of rejections be accounted for.

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As a matter of fact, the large proportion of rejections at this preliminary examination attracted the attention of the writer some fifteen years ago, when he was one of the secretaries of the College. They seemed to him to be beyond all reason and common sense. As a result of this conviction he succeeded in getting a meeting in Montreal of the heads of nearly all the Roman Catholic and large Protestant teaching institutions of the province. It was held in the rooms of the Medico-Chirurgical Society of Montreal. The attendance was large, the situation was freely discussed, and the conclusion come to was, that not a single institution in the province gave an education which fitted for presentation for this examination.

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If such a conclusion was correct, it was the legitimate outcome of that meeting, that either the education should be altered or the examination brought on a line with that given. But neither has been done, and the result is that the wholesale rejections go on. This is not fair; it is not just, and we appeal once more through this journal for a re-examination of this matter by the present Board, which we believe is composed of men who desire to act in the best interests of the profession.

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At the request of the editors of the *Journal of Laryngology, Rhinology and Otology*, published in London, we reproduce the following extract from their April issue:

"An Appendix to the 'International Directory of Laryngologists and Otologists,' compiled by Mr. Richard Lake, is in course of preparation. In it will be found corrections of names and addresses already given, an additional list of names and addresses received since publication and an obituary list.

". . . . Considerable additions have been obtained for the foreign list, which will materially add to its value and completeness. The decision of the Editors of the *Journal of Laryngology, Rhinology and Otology*, under whose auspices

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the Directory is published, to allow no name to be inserted in the British list for which sanction has not been given in writing, at once explains some omissions and criticisms. The editors, whilst desirous of making the Directory as complete as possible, consider it best to adhere to this course. It is therefore hoped that all engaged in the practice of Laryngology, Rhinology and Otology will assist as far as possible in making this useful work complete," by sending in their names and addresses to the Editor, "International Directory of Laryngologists and Otologists,' 129 Shaftesbury Avenue, W. C.

## UNIVERSITY OF BISHOP'S COLLEGE.

### FACULTY OF MEDICINE.

We have received the calendar for 1900 1901 of the above College. It is growing with age, and in bulk is very voluminous compared with the modest pamphlet which announced the birth of this Faculty thirty years ago. A glance through its contents proves that Bishop's College is well equipped in every way for its work, and that all who select it for their *Alma Mater* will not regret their choice. In Midwifery and Gynecology this school is especially strong, and these two branches have much to do with success in the profession. Its graduates are to be found in every quarter of the world, and occupying a leading position wherever placed. The Annual Calendar can be had by applying to either Dr. Ross, Registrar; Dr. Fish, Asst. Registrar.

## PAN AMERICAN EXPOSITION 1901 AT BUFFALO, N. Y.

Dr. A. L. Benedict, of Buffalo, who has been appointed superintendent of the Ethnological and Archæological departments of this exposition, writes us as follows:

"Many members of the medical profession are interested in the study of American ethnology and archæology, and not a few have valuable collections of Indian relics and skeletons from Indian graves. Those not directly interested in this study are so circumstanced as to be aware of the hobbies of their neighbors and could doubtless furnish the address of collectors. I should be greatly obliged for in-

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formation and for the loan of collections for the use of this department of the exposition. Exhibits which represent study in some special line of American Ethnology and Archæology will be particularly suitable."

## CANADIAN MEDICAL ASSOCIATION.

The attention of the Profession in the various Provinces is called to the Annual Meeting of the Canadian Medical Asseciation at Ottawa, September 12th, 13th and 14th, 1900. The preliminary programme is now being arraged for. Members intending to present papers are requested to send in their names and the titles of the papers. Mr. Edwin Owens, of London, England, will deliver the address in Surgery. The attendance, it is believed, will be large. Ottawa is a very central point, and the secretary promises a very interesting meeting. Within the last few years the attendance at the meetings of this association has been steadily increasing; we hope this year will not show any change in this respect.

The undersigned will be glad to give information regarding the meeting: A. R. Marsolais, M.D., 159 St. Denis st., Montreal (Vice-President); J. Alex. Hutchison, M.D., 70 Mackay st., Montreal (Secretary); F. N. C. Starr, M.D., 471 College st., Toronto (General Secretary).

The *Journal of Surgical Technology* is the title of a new periodical, to be published monthly, beginning July 1, 1900. It will be devoted to the consideration of the technic of surgical procedures, at a subscription price of $1.00 a year. Valuable premiums are offered with the first subscriptions. Address the Technique Publishing Co., 404 East 14th St., New York City, N. Y., for sample copy.

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# PERSONAL.

Dr. F. J. Shepherd, of Montreal, has been elected President of the American Dermatological Association, which will hold its next meeting at Chicago in June, 1901.

The following Montreal medical men left for Europe the early part of July: Sir William Hingston, Dr. T. G. Roddick and Dr E. P. Lachapelle.

Dr. Birkett has been appointed Major of the Bearer Company. just raised in Montreal. His two Lieutenants are Dr. Kenneth Cameron and Dr. Wylde.

Dr. Harry Bell has temporarily assumed the position of Surgeon on the well-known Allan liner "Parisian."

Dr. Weir Mitchell, of Philadelphia, was in Montreal for a day early in June, on his way to his salmon fishing ground on the "Cascapedia."

Dr. Fraser (M. D., McGill, 1897) has assumed the duties of resident physician at the Laurentian Sanatorium, St. Agathe, Que.

Dr. Otis, of New York, died recently at New Orleans. He gave up practice some years ago, on account of failing health. Among the medical men of New York he occupied a prominent position as a specialist on Genito-Urinary Surgery. He was one of the early members of the Restigouche Salmon Club at Metapedia, Que., and was an enthusiastic angler.

Dr. Lopez (M.D. Bishop's College, 1900) sailed in June for Edinburgh, where he proposes to take out the triple qualification.

Dr. N. C. Smillie (M. D. Bishop's, 1882) left early this month, for British Columbia to look after some mines in which he is interested.

# Book Reviews.

**Normal Histology.** By Edward K. Dunham, Ph.B., M. D., Professor of General Pathology, Bacteriology, and Hygiene, in the University and Bellevue Hospital Medical College, New York. Second Edition. Illustrated with 244 engravings. Lea Bros. & Co., New York and Philadelphia, 1900.

There being many excellent text-books of Histology which already meet the requirements of students of the subject, a new work on Histology, in order to be successful, must recommend itself by its thoroughly practical tone, its clearness of language and its modern treatment of the science. Now, the chief merit of Dr. Dunham's work lies in the brevity and clearness of its descriptive text, enriched by a wealth of carefully selected drawings, and in the

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simplicity of the methods for preparing specimens for microscopical study.

The work consists of two parts. Part I. is devoted to an account of the structure of the cell, the elementary tissues, and the organs of the body. Part II. deals with histological methods.

Dental students will be disappointed with the author's too brief description of the structure of the teeth, but they must remember that a detailed account of every tissue and organ does not fall within the scope of an elementary text-book. The account of the structure of the nervous system is well abreast of the teachings of Golgi, Cajal and others, who by their investigations have effected an entire reconstruction of our conceptions of the minute structure of the central nervous system. We take pleasure in recommending this work to the student as a serviceable guide, designed to supplement the knowledge acquired from his laboratory experience.

A. B.

**Surgical Pathology and Therapeutics.** By John Collins Warren, M.D., LL.D., Professor of Surgery in Harvard University; Surgeon to the Massachusetts General Hospital. Illustrated. Second edition, with appendix, containing an enumeration of the scientific aids to surgical diagnosis, together with a series of sections on regional bacteriology. Philadelphia; W. B. Saunders, 925 Walnut St. 1900. Price, cloth, $5.00 net; sheep or half Morocco, $6.00 net. Canadian Agents, J. A. Carveth & Co., Toronto, Ont.

This volume on Surgical Pathology is assuredly a most valuable contribution to medical and surgical literature. It is the second edition (the first edition appeared about five years ago) of this important work, containing in addition an appendix of sixty-five pages. The work is a decided improvement on the first edition. The scientific portion of a surgical education was formerly regarded as something apart and ornamental, but it has now become an eminently practical feature of the students' curriculum. No young practitioner can be regarded as thoroughly equipped for surgical work who is not both a good pathologist and an expert bacteriologist. An attempt is therefore made in this book to associate pathological conditions as closely as possible with the symptoms and treatment of surgical diseases, and to impress upon the student the value of these lines of study as a firm foundation for good clinical work. In the second edition the author states that the attempt has been made to embody all the important changes in a new appendix, which replaces the old one and the chapter on Antiseptic Surgery. In this new chapter the author has aimed to present in as practical a manner as possible the resources of surgical pathology. In addition to an enumeration of the scientific aids to surgical diagnosis, there is given a series of sections on what may be termed regional bacteriology, in which are given a description of not only the flora of the part affected, but also the general principles of treating the affections which they produce, based upon the latest views of the best authorities. The work is written in an easy and yet masterful manner, and as it deals with a subject of the greatest interest and importance to the rising surgeon (who should endeavor to keep abreast of the times) few medical or surgical men can afford to be

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without this valuable work. The chapter on bacteriology, which is now so important, is deeply interesting, also that dealing with tuberculosis. In fact, the book from the beginning to the end is so written that one's interest never slackens, nor is its perusal at all wearisome, considering the highly scientific character of the work. One has only to read to fully appreciate the high merit of the book. The general get-up of the volume is up to the usual high standard of the publishers. R. C.

**Post Mortem Examinations, Methods and Technique.** By John Caven, B.A., M.D., Toronto; L.R.C.P., London. Illustrated. J. A. Carveth & Co., Toronto, Ont.

This work is a small handbook for the use of students, dealing with the usual method of making post-mortem examinations, whether for scientific investigation or for medico-legal purposes. Such instructions are found in most works on legal medicine, more often detailed and valuable. This volume, in addition, has a chapter on the preservation of tissues, and in the early part of the book a list of an outfit for bacteriological use. With regard to the letter press, the instructions are given with clearness and show a practical knowledge of the subject. We would, however, criticize the method of opening the right side of the heart. In order to expose all the valves of the pulmonary artery in their entirety, a section close to the interventricular septum, and not "half an inch" to the right, is the one usually adopted, this section to be continued round the apex of the heart to a point midway between the orifices of the venæ cavæ. This will show the tricuspid valves also entire.

The illustrations of the work are semi-diagrammatic, and not very accurate, a fault easily rectified in a future edition by copies of the excellent cuts in Quain's or Morris' Anatomy. Illustrations for Students to be useful must be accurate even if semi diagrammatic, and these pictures of the brain and heart are crude and misleading. The one of the convolutions of the brain is exceptionally poor. When students see such imperfections issued by their teachers, they are inclined to quote "Quis custodiet ipsos custodes."

As before stated, instructions as given in the book under review are found in all the most important works on legal medicine, and we very much doubt the utility of a special work of this kind unless accompanied by a series of illustrative cases, comprehending most of the forms of natural death, and selected for other specific lessons. These would show how the procedure necessarily differs in each case submitted to the expert pathologist or medical jurist.

The details of pathology, as of anatomy, students must learn, but the application of a knowledge of the one as of the other is best taught by instruction on selected individual conditions; to recognize the abnormal from the normal, and how to proceed in each case under observation.

It is only, as we hold, by a careful description and record of illustrative cases that works of this kind can be made complete and acceptable.

It would be well to study the procedure indicated by the distinguished pathologist Virchow, in his admirable manual on post-mortem examinations. C. H.

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**Diseases of the Eye.** By Edward Nettleship, F. R. C. S.; Ophthalmic Surgeon at St. Thomas Hospital, London; Surgeon to the Royal London (Moorfields) Ophthalmic Hospital. Revised and edited by Wm. Campbell Posey, A. B., M D., Ophthalmic Surgeon to the Howard and Epileptic Hospitals, Philadelphia; Assistant-Surgeon Hills' Eye Hospital; Fellow of the College of Physicians of Philadelphia; Associate Member of the American Ophthalmological Society, etc. Sixth American from the Sixth English Edition. With a supplement on Examinations for Color-Blindness and Acuity of Vision and Hearing, by William Thomson, M. D., Emeritus Professor of Ophthalmology in the Jefferson Medical College of Philadelphia. With 5 colored plates and 192 engravings. Lea Bros.-& Co., Philadelphia and New York. 1900.

Mr. Nettleship's book has been so frequently reviewed that further comment on it is unnecessary. The fact that a sixth American edition is called for shows that Nettleship's "Diseases of the Eye" is a standard text-book in America as well as in Great Britain. The editor has done his work well, and has added much useful information, especially in the way of treatment.

G. W. M.

**Progressive Medicine, Vol. II, 1900.** A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia-Medica in Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 401 pages, with 81 engravings. Lea Brothers & Co., Philadelphia and New York. Issued quarterly. Price, $10.00 per year.

An examination of this, the second volume of the 1900 series of *Progressive Medicine*, reveals the very practical lines which have been followed by its contributors.

Dr. Coley, in his article on "Surgery of the Abdomen, Including Hernia," treats of one of the newest and most interesting phases of modern surgical practice, namely, operations upon the stomach. With admirable detail, this able authority describes the diagnostic symptoms, the methods of operating, treatment and the management of convalescence.

The ever-important subject of appendicitis is next considered from a practical standpoint, the merits of a newer method of operating being carefully investigated. Bassini's operation in Hernia is described in practical detail, and operations upon the intestines, colon and liver are exhaustively considered in the aspects of operation and results. Abdominal tumors and the methods for their diagnosis, come next, and this is followed by a most interesting consideration of the use of the X-ray in detecting abdominal calculi. The illustrations given in this section, as in fact is the case throughout the volume, are most helpful.

Dr. John G. Clark gives an admirable résumé of the progress made in Gynecology during the past year. The various topics

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discussed are too numerous for special mention, but the sections on "The Treatment of Pelvic Peritonitis," "The Treatment of Inflammatory Pelvic Exudates," "Ultimate Results in Treatment of Retroversions," etc., are especially interesting.

Dr. Stengel covers a list of diseases, from which arise a large proportion of human ills, following the preliminary pages in which the diagnostic value of the varying conditions of the blood is dealt with. Such pathological conditions as anemia, chlorosis, leukemia, etc., are practically considered. The diseases due to metabolism logically follow, and as the subject matter is treated in great detail. Dr. Stengel's section must prove of great practical value to the physician.

In treating of his specialty, Dr. Jackson has aimed to supply the requirements of the general practitioner rather than those of the specialist in Ophthalmology. He has endeavored to so equip the practitioner with the most recent knowledge in this branch of medicine as to enable him to successfully treat the majority of cases which may come before him. In fact, this entire volume is full of practical information to an extent which has rarely been equalled in a single book. The aim of the editors and contributors to produce in narrative form the record of the year's events has been ably carried out. Each succeeding volume of this series emphasizes the degree to which this original and ingenious plan has been perfected, and the necessity for increasing the large editions with each succeeding volume attests the growing popularity of the work. F. W. C.

**A Dictionary of Medicine and the Allied Sciences,** comprising the pronunciation, derivation and full explanation of Medical, Pharmaceutical, Dental and Veterinary terms, together with much collateral descriptive matter, numerous tables, etc., by Alexander Duane, Assistant Surgeon to the New York Ophthalmic and Aural Institute; Review of Medical Terms, for Webster's International Dictionary. Third edition. Enlarged and thoroughly revised, with eight full page colored plates. Lea Brothers & Co., Philadelphia and New York. 1900.

Within the last few years a complete dictionary of medical terms has become an absolute necessity in the library of every reading physician. Such a work to be of value must be an up-to-date one, so numerous has been the additions to our medical vocabulary. It has evidently been the aim of the author to give sufficient information concerning every word that is likely to be met with in the course of professional reading. So numerous, however, is our vocabulary to-day that space for the insertion of all useful terms has only been secured by the omission of words that have practically become obsolete. Practical utility rather than historical tradition has controlled the selection of matter; hence, words are omitted which to-day are only found in dictionaries. The space thus gained has been used for the insertion of much descriptive and explanatory matter, which would be very inadequately represented by mere definition, no matter however full. Thus under the principal diseases a sketch is given of their causation, symptoms and

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treatment; under the more important organs, an outline of their structure and functions; under each drug, an account of its action and therapeutic uses, and of all the preparations of it official in the latest editions of the pharmacopœias of the United States, Great Britain (1898) and Germany. The important physiological functions and generic biological and chemical terms receive similar extended explanation. This being the third edition of this work, it contains a vast amount of new material representing the great advances made in all branches of medicine since the previous edition was issued. It has also been revised in every part, and beyond all question is the very latest and best of its kind. The dental and veterinary terms have been supplied by experts in these departments of medical science. To fasten in the memory a vivid and enduring recollection of the meaning of words, no aid is equal to that furnished by derivation. Special care has therefore been taken to state and define the original words from which medical terms are derived. To render this feature of the work available for those unfamiliar with Greek, all such derivations are given in ordinary type. Vowels long by nature have been appropriately marked, owing to the important influence of natural quantity in determining the pronunciation of a word and the form of its derivatives. As the essence of a dictionary lies in its definitions, no pains have been spared to make the explanation of each word clear and sufficient. Where words have several distinct meanings, clearness has been promoted by the use of numerals to emphasize the distinction.

The colored plates appear for the first time in this edition, and have been selected with a view to their practical utility, as illustrating subjects which are of importance and general interest, but which are not portrayed in the ordinary text-book.

The publisher has done his part more than well. The typography is compact, but pleasing. It is truly marvellous what an amount of matter each page is made to contain.

F. W. C.

**A Handbook for Nurses.**—By J. H. Watson, M.D., Edin. Late House Surgeon, Essex and Colchester Hospital; Assistant House Surgeon, Sheffield Royal Infirmary and Sheffield Royal Hospital. American Edition under the Supervision of A. A. Stevens, A.M., M.D., Professor of Pathology in the Women's Medical College of Pennsylvania; Lecturer on Physical Diagnosis in the University of Pennsylvania; Physician to St Agnes' Hospital, Philadelphia. Published by W. B. Saunders, 925 Walnut Street, Philadelphia, 1900. Can be obtained in Canada from J. A. Carveth & Co., 413 Parliament street, Toronto.

Although there are many works on nursing, the majority fail either to contain sufficient information or contain too much technical knowledge for the average nurse. In this work the author has, we think, written a most valuable work for nurses. There is a great deal of information on almost everything that a nurse should know. A little knowledge is a dangerous thing, and never

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more so than in a nurse. A well trained, well educated nurse will never attempt to usurp the rôle of a medical man, but will be as his right hand, whereas an ill-educated one is apt to do so and so bring discredit on her nursing sister and sore trouble to the doctor. We can most heartily recommend this work, and would like to see a copy of it in the possession of every one engaged in nursing in this country.

# PUBLISHERS DEPARTMENT.

## LITERARY NOTES.

Two of the freshest and most important of recent articles on China, namely, Mr. Gundry's acocunt of "The Last Palace Intrigue at Peking," and Mr. Douglas's hopeful view of "The Intellectual Awakening of China" will be found in *The Living Age*. Mr. Gundry's article in the number for July 7 and Mr. Douglas's in the number for July 21.

One of the most delightful of recent contributions to natural history, popularly treated, is Mr. Mathias Dunn's study of "Mimicry and Other Habits of Crabs" in *The Living Age* for July 7. It is marked by close and sympathetic observation and contains curious facts which will be new to most readers.

One crisis at a time is all that most people have leisure to consider, and the very grave crisis in China may distract attention from "The Coming Afghan Crisis" which Mr. Demetrius C. Boulger considers in an article reprinted from *The Fortnightly Review* in *The Living Age* for July 14 Nevertheless, the facts which Mr. Boulger presents are interesting, and, to the English reader, must be somewhat startling.

The last number of *The Quarterly Review* contained an innovation in the shape of an article written in French by Mr. Ferdinand Brunetière, and not translated. Mr. Brunetière undertook to give his English friends and readers some idea of the present French feeling toward England and the reasons for it. *The Living Age* presents the article in an admirable translation, and makes it its leading article in the number for June 30.

"Imperialism" is so much under discussion in the United States at the present time that the *Scottish Review's* article on "The Literary Inspiration of Imperialism," which *The Living Age* prints in its number for June 30, is particularly timely.

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CANADA
# MEDICAL RECORD

AUGUST, 1900

## Original Communications.

### SHALL WE TELL WOMEN WITH UTERINE CANCER THE NATURE OF THEIR DISEASE?

By A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., England.
Professor Clinical Gynecology in Bishop's College, Montreal.

No more unpleasant task perhaps ever falls to the lot of the tender-hearted physician, and I think the majority of physicians are tender-hearted, than to have to tell a patient that she is suffering from malignant disease. Some deliberately shirk this unpleasant duty on principle, believing that we are not called upon to tell her the truth in these circumstances; while others avoid it from expediency because they dislike to cause pain, or because they think that it pays better to say something pleasant which will cheer up the disconsolate one for the time and leave a temporary agreeable impression on her mind. In the course of a newspaper interview with a great London surgeon, whose name is known all over the world, while speaking of tact as an element of success, he says that the successful physician will not tell a woman that she is suffering from cancer; and one of our greatest Canadian physicians evidently holds the same views, as in consultation over their cases he invariably tells the patient that they will be better soon. As some of these patients were dead two or three weeks later his prognosis was correct in a sense, but not in the one in which the patient would be supposed to take it. The view taken by these two great men, and by many others in the profession, is equally held by a great many of the laity, as seems certain by the number of people who have asked me to tell them

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truly what was the matter with their sick friend, but on no account to let the sick one herself know the nature of her malady. Not only do the friends almost invariably take this course, but, strange to say, I have known the patient herself beg that I would not tell her the truth.

Notwithstanding all this, I venture to differ from these doctors, from the patients and their friends, and I wish to enter a firm protest against any other course being adopted than to tell the truth every time; and I think I can show that this is our duty for many reasons. For those (and I hope they are few) who require any other argument than duty, I think that I can prove that it does not pay to deceive a patient even under the mistaken idea that good may come of it.

I am not saying anything about telling the friends what is the matter; for when they have brought me a patient and mysteriously called me to one side to whisper that I could tell them, but not to tell the patient, I have often said to them, "the patient is the only one who has any right to know; what is the matter with her and what she tells me are alike profound secrets; I will tell her and she can tell you if she likes; but I will not tell any one else."

Is it right to tell the truth? At first sight I will admit that it appears more humane not to tell a woman that she has cancer of the womb, but in reality this course is most cruel; for, in each of the three stages into which I will divide the progress of the disease, the woman has an immense stake at risk; she has everything to lose and nothing to gain by being kept in ignorance of her actual condition, and she has a right to know it whether she wants to or not, from the moment the physician knows it himself. In the first stage of cancer of the womb the disease is absolutely local; that is to say it occupies a small spot on the angle of a laceration or is limited to the endometrium. During this stage the disease is positively and entirely curable by the removal of the womb. Vaginal hysterectomy for cancer in this stage by a good operator has at the present time a death rate of two or three per cent. at the very most. Alas, it is bad enough to think that so few cases are even diagnosed at this stage, without wishing that the few which are diagnosed

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should be deceived into a fool's paradise, while their physician, whom they trust to save them when they could be saved, quietly stands by and with the friends becomes a conspirator to hide their danger from them, until it is too late to escape it. How can she hold out her hand for help if she does not know that she is in danger. I for one decline to place such a responsibility upon my conscience or to become a plotter against her life, as I would be if I knowingly and willfully concealed from her the one fact that she had cancer of the womb, and the other that vaginal hysterectomy would save her. I shall never forget the remorse of a medical friend who brought me a patient with a large cancer of the uterus with the broad ligaments infiltrated with the disease which he had been treating with caustics for six months, and which was then too far advanced to permit of hysterectomy; looking me straight in the eyes he asked me whether, if he had brought her when he first discovered it, I could have saved her, and I was obliged to answer that I believed I could have done so. He only replied, "I will never forgive myself," and from the tone in which he said it I believed him. And yet he only lost her life through unintentional ignorance of her true condition and not through willful deceit, and he was not therefore anything like so much to blame.

In what I call the second stage the cervix is invaded, the broad ligaments are full of cancerous tissue and the lymphatics are infiltrated with it. The patient is alternately being drained of her life blood by irregular hemorrhages, which she attributes to the change of life, and poisoned by the absorption of decomposing and gangrenous material, which keep her in a burning fever. Her presence, moreover, is made loathsome to her friends by reason of the foul smelling discharge. And yet she does not know that she is a hopeless case of cancer of the womb. Why tell her? Because we can prolong her life, diminish her suffering, and not only thus make her life endurable to herself but render her unoffensive to her family by a thorough use of the curette and cautery. Under an anesthetic we can do all this without any danger or causing any pain, and in a few days she will feel so well that she almost doubts the accuracy of the diagnosis which she has to

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thank for her improved condition. I have had, unfortunately, too many of these cases and too few of those in the first stage, but I have had the pleasure of seeing apparently dying woman almost at once become comparatively well. In a few cases I have curetted them a second time at the end of three months more, but as a rule the one curetting has sufficed, and they have died peacefully and painlessly from cancer of the liver from six to nine months later, surrounded by their friends to whom they were no longer an object of disgust. Now, how can they avail themselves of this merciful treatment unless they know the necessity for it? It is more than we can expect, and certainly more than we often find, a women willing to submit to an operation without knowing the nature of the operation and why it is to be done. If their condition is made known to them they readily consent to have it performed.

In the third stage, where the whole pelvis is filled with a cancerous mass and the bladder and rectum involved, and nothing is to be done except to make death painless, what should be our answer to the woman who asks us what is the nature of her disease, and whether we can cure her. I have had such patients ask me if they could be quite cured in a month, when as events turned out they were fated to be dead and buried in less than that time. Shall we follow the golden rule and do to this poor woman as we would be done by if our positions were reversed? And would we not wish to know the truth so that we might prepare for death?

At the beginning of this article I said that duty should be our first consideration, and I hope I have shown that it is our duty in this case, as in all cases, to tell the honest truth. But even from the infinitely lower standpoint of expediency, I hope to show that it pays to tell the truth.

When we hear a friend lying from kindness or expediency, does our opinion of that friend go up or down? When we have heard him telling a woman with cancer that she will be all right soon, and telling us five minutes later outside the house that he believes she will be dead in a week, and when we have heard him saying the same two opposite things in twenty other cases, will our faith in his word be as

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implicit as it would be if we had heard him on every occasion telling the truth, the whole truth, and nothing but the truth? If we weakly comply with the request of the friends and lie to a patient, what will these same friends think of our truthfulness when it is their turn to consult us? Even if we told them the truth, would they believe us? Certainly not, if they knew that we had lied to others in the same circumstances.

We see the effect of this mistaken policy almost every day in patients who have been under several doctors. When we go to examine them they ask us if we will hurt them; if we say "no," they exclaim, "I know you will." If we are going to hurt them it is better to tell them so before hand, and they will bear it quite bravely. It is only after the second or third visit that we will succeed in winning their confidence by telling them the truth every time; and then when we pick up the speculum they no longer jump up saying, "Is that a knife you have in your hand?" By showing them each instrument and explaining what we are going to do, they will no longer fea or doubt us. And this is how it pays to tell the truth; little by little you will build up a circle of friends who will tell their friends that they can depend upon what Dr. so-and-so tells them, and the staunchest friend of all will be the poor dying woman whom you have given a chance to prepare for death. Next to her will be the woman who has been curetted and made comfortable and endurable to her friends; and last but not least the woman will thank you for the truthfulness to which she owes her life, and by which she has been saved from a painful and loathsome death.

Not only does the reputation of, and faith in, the individual physician increase in proportion as his word can be trusted implicitly, but the faith of the public in the profession as a whole would be still greater if even in these distressing cases, no matter how good and kind the motive may be, our invariable rule with every one of us would be to leave nothing undone to make an early and accurate diagnosis, and once that has been done, not to lose a single hour in having the proper treatment carried out.

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# QUARTERLY RETROSPECT.

(DEPARTMENT FOR DISEASES OF THROAT AND NOSE.)

UNDER THE CHARGE OF

GEO. T. ROSS, M.D., Laryngologist to the Western Hospital,

Professor of Laryngology and Rhinology, Faculty of Medicine,
University of Bishop's College, Montreal.

*Atrophic Rhinitis.*—This almost incurable disease was the subject of a very exhaustive discussion at N. Y. Academy of Medicine in March last, when a symposium was given by various American physicians. The etiology of the disease is not yet satisfactorily solved, as is evident when various authors endeavor to support as many theories as were brought forward on the occasion referred to. Bosworth has for the past twenty years maintained that the disease is a development from the purulent rhinitis of childhood, and as far as my own experience goes I have found in many cases, upon strict enquiry, that this theory is well supported by evidence.

The declaration of Jonathan Hutchison, that inherited syphilis was an etiological factor in every case of atrophic rhinitis, was shown by Wright to be ill founded, while it was admitted that, although many cases have a syphilitic basis, yet all of them have not. Gerber's cases were quoted to show that both syphilis and rachitis were frequently important factors.

The importance of recognising functional collapse of the nasal tissues from atrophic rhinitis was shown by Clarence Rice. Some of the points of difference are as follows:—Functional collapse is not often seen before young adult life, when the effects of combined malnutrition begin to be noticeable, while atrophic rhinitis may often be seen in children at the age of ten. Collapse without atrophy is seen in the poorer classes, or at least with people living in bad hygienic state, and true atrophy in people of any class. Anemia and debility seen in collapse is not necessarily seen in atrophic rhinitis. In the simple dry nose of anemia we find a mucous membrane all shades of palor such as we would expect, but smooth, pressed down tightly on the turbinals which retain their contour, while in atrophic rhinitis, if the patient is well

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nourished, any color from that of acute coryza to a dirty gray is found. The surface is granular and the turbinals are more or less destroyed by atrophy. There is also abundant mucopus and crusts in atrophic rhinitis, while in functional collapse almost no secretion is present. Authors generally think that vascular collapse very rarely ends in atrophic rhinitis. The diagnosis is important because the collapse is curable by proper means, it being only of temporary character, while the treatment of the atrophic disease is discouraging.

As to treatment of atrophic rhinitis, the two main indications are local cleansing and stimulation. In children little can be done because they will not as a rule submit to treatment. Alkaline solutions are best to use, and they should be used both before and after a spray of peroxide of hydrogen. Oils should be used sparingly. Menthol improves the quality of secretion and lessens the quantity. The solution should be as strong as the patient can endure, beginning with weaker solutions. Formaldehyde is an ideal remedy for this disease—one part to 5000, and weaker or stronger may be sprayed after the saline spray. Borolyptol is a good form of this drug, and can be diluted 10 to 15 times. Ichthyol in the form of Keroline-Ichthyol 2 and 5 per cent. solutions is advocated, and I can testify to its benefit. The antitoxine treatment formerly advocated has been abandoned. As one-fifth of the subjects of this disease are in ill health, some constitutional treatment is essential. Any existing dyscrasia has to be specially regarded. Change of climate to suit any defect in constitution is called for where it can be done. Iron, arsenic, iodine, cod liver oil, is often needed, and even inunction of oils has given good results. Mechanical means, such as tampons, plugs and bougies, are often useful to stimulate the shrunken glands to secretion. Curetting the diseased membrane has been advocated and the various forms of electricity often are useful. Vibratory massage is thought by some to deserve a leading place amongst remedies, but this demands prolonged applications, and most patients cannot devote as much time as is required for good results. In this connection prevention is dwelt upon as being worth everything, and the care of nasal diseases promptly when they

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assert themselves, either in childhood or later, is the best means of avoiding this disease.

*Hypertrophied Turbinals.*—Submucous linear cauterization is advocated by Pierce as superseding all other methods of reducing hypertrophied turbinals. The technique is simple and the advantages claimed are—cheapness of outfit, reliability, simplicity, not terrifying to nervous people, painless under cocaine, does not destroy mucous membrane, reaction slight, and much less than follow electrical cautery.

*Death after removing adenoids, due to hæmophilia*—This case, related by Dr. R. Sachs (Hamburg) died four days after operation, all means having failed to arrest the bleeding. The operation was done before the family failing was ascertained, the bleeding tendency being easily traceable. The importance of invariably asking before operation if any evidence of hæmophilia has been at any time noticed is emphasized.

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# Selected Articles.

## TREATMENT OF INOPERABLE CANCER.

By WILLIAM B. COLEY, M. D., New York.

It is unnecessary to state here that however great were differences of opinion as to the value of operations upon cancerous tumors a quarter of a century ago, to-day we are practically all agreed that early and complete removal by the knife, while far from ideal in results, still furnishes the best hope of permanent cure of all the methods with which we are acquainted. This, it is needless to say, applies only to operable tumors, and here at once arises a difficulty in what shall we regard as operable and what as inoperable. Certain general rules may be laid down, but the classification of doubtful cases will have to be left to the personal judgment of the surgeon.

I believe that in recent years much harm has been done by surgeons attempting impossible operations, or performing operations upon patients in cases in which it was clearly impossible to remove the entire tumor. Not infrequently

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such operative interference greatly increases the rapidity of the growth of the tumor, and moreover the high mortality which often attends these operations has the unfortunate effect of deterring others suffering from cancer from submitting to operation at a time when the chances for permanent cure are great. We have no right to perform an operation that is attended with the gravest risk unless there is some prospect of being able to save the patient or at least prolong or render more comfortable his life. The fact that the patient himself desires the operation and is willing to assume the risk should have no influence in causing us to break sound surgical principles.

In the brief limits of this paper it will be impossible to speak in detail of all the various methods of treatment employed in inoperable cancer. When we consider the well-established fact that cancer is rapidly increasing throughout the world, and that in spite of the vast improvements in results of operative treatment, three-fourths of all cases become inoperable, we see at once the importance of the subject. If we cannot find any means to cure these patients it behooves us to do all in our power to discover the best methods of rendering the remainder of their lives endurable.

Personally I have long believed the solution of this problem of treatment to be so intimately connected with that of the etiology of cancer that there is little hope of accomplishing much with the former until the latter has been determined.

Eight years ago, in a paper before the Academy of Medicine, I expressed my firm belief that cancer was due to an infection from some extraneous micro-organism. It seemed to me then that the clinical and experimental evidence in favor of this theory was even then sufficiently strong to justify one in hoping that scientific proof would soon be forthcoming.

Those of us who had the privilege of listening to the admirable and convincing papers of Drs. Park and Gaylord at the last meeting of the Academy describing the recent experimental researches of San Felice and Plimmer, as well as their own, cannot but feel hopeful that the problem is nearing a solution.

The present paper will permit only of a brief discussion of the treatment of inoperable sarcoma.

## THE TREATMENT OF INOPERABLE SARCOMA WITH THE MIXED TOXINS OF ERYSIPELAS AND BACILLUS PRODIGIOSUS.

The results of this method during the past year have

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given me no reason to change the conclusions already expressed in earlier papers.

I still find that round-celled sarcoma is much less susceptible to the inhibitory action of the toxins than spindle-celled, and the melanotic is even less affected.

In regard to the method of preparing the toxins and the technique of administration I have nothing new to add. The preparation which I believe to be the best is the mixed unfiltered toxins of erysipelas and bacillus prodigiosus made from cultures grown together in the same bouillon and sterilized by heating to 58° C. In children and persons much reduced in strength it is safer to use the filtered toxins. The preparation is much weaker; the relative strength of the two being about 1 to 10. Toxins to be of value must be made from very virulent cultures, the virulence being kept up by frequently passing the cultures through rabbits. The preparation being bacteriologically sterile, it can be used with perfect safety in a general hospital ward.

*Dosage*:—The dose depends largely upon the vascularity of the tumor and upon the condition of the patient, and injections when possible should be made directly into the tumor. The initial dose should seldom be more than one half a minim diluted with boiled water, which should be gradually increased until the reaction temperature reaches 102° or 103° F. After the dose has been increased to one minim dilution is unnecessary. When the injections are given subcutaneously remote from the tumor, much larger doses may be borne. Sometimes 12 or 15 minims may be given before the chill is produced.

*Aseptic precautions*:—Inasmuch as the administration of these as well as other toxins unquestionably increases the liability to infection, if pathogenic germs are present in the vicinity, great caution should be exercised in sterilizing the hypodermic needle as well as the skin. If the tumor be ulcerated or broken down, great care should be taken to keep the parts aseptic. Lack of such precautions has been the cause of death in two fatal cases. In regard to the duration of the treatment, fortunately we are able in most cases to tell within three or four weeks whether or not the toxins are likely to be beneficial. If no improvement is apparent at the end of this time, it is seldom worth while to continue the injections. In most of the successful cases marked improvement has occurred within a week after the first injections. The growth may disappear in one of two ways. If very vascular there may be rapid breaking down and sloughing of the

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tumor, while fibrous elements predominate. Absorption without breaking down is the more likely to occur.

If improvement occurs the toxins should be continued until either the tumor has entirely disappeared or until it has become evident that the injections have lost their controlling influence, as evidenced by the further increase in size.

The question of harm resulting from long continued injections is a very important one. That the toxins may be given for very long periods without injury to the patient has already been proved. In one patient with a three times recurrent rapidly growing carcinoma of the breast and axilla the toxins were administered for two and a half years. The doses were moderate and averaged two a week. The tumor disappeared, the patient gained ten pounds in weight and her general health remained good, until at the end of this time there was both a local recurrence and abdominal metastasis, the disease running a very rapid course and causing death in six months.

In another patient with eight times recurrent spindle celled sarcoma of the chest wall, the toxins were administered with occasional intervals for nearly four years. The disease was held in check by small doses. The patient, who was a well known physician, is at present in perfect health, nearly six years from the beginning of the treatment.

In order to properly explain the curative action of streptococcus of erysipelas and its toxins upon sarcoma, I am convinced more than ever that this action can be explained only on the theory that sarcoma is of a micro-parasitic and infectious origin. I will even go further and say that I believe this action of the toxins furnishes additional evidence in support of the infectious origin of sarcoma and carcinoma. In view of the steady accumulation of successful cases, the early attempts to explain the disappearance of these tumors, upon the theory of mistaken diagnosis or spontaneous disappearance, no longer requires serious consideration. It would be clearly unfair to rule out the cases cured withtoxins on the ground of error in diagnosis without including in the same manner the cases cured by operation. Both classes of cases have been submitted to the same standards of diagnosis with one important exception, viz. that the cases treated with toxins have been submitted to far more severe tests. In the majority of these cases the clinical and microscopical diagnosis was confirmed by a number of the best surgeons and pathologists, instead of by a single individual.

After an experience of upwards of eight years with this method of treatment, the question may be fairly asked,

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"Has the method any permanent value, and if so, what are its limitations and dangers?" The question can only be answered by giving a careful resumé of the final results in the cases thus far treated.

This I shall attempt to do as in as few words as possible. Before doing this I should like to briefly report a few unpublished cases.

## RECENT UNREPORTED CASES OF SARCOMA TREATED WITH TOXINES.

*Case* 1. *Recurrent Sarcoma of the Tibia: Amputation Advised.*—F. W. F., male, age 27; unmarried; was referred to me on February 12, 1899, by Dr. J. M. Stewart, of Chesley, Ontario. His family history was good and there was no tuberculous or specific history. In July, 1898, a swelling over the tibia of the left leg was noticed. It slowly increased in size, and on November 25, 1898, it was operated upon by Dr. Stewart, who made an incision down to the bone and scraped out as much of the diseased tissue as possible. The portion that was removed was sent to Dr. John Caven, Professor of Pathology at the University of Toronto, who, after a careful examination, pronounced the growth a spindle-cell sarcoma. The wound healed slowly, and a short time afterward the disease returned locally.

Physical examination showed a tumor over the middle and anterior portion of the left tibia about three by four inches in size, projecting above the surrounding tissues to a distance of ½ to ¾ of an inch. Over the central portion there were two small ulcerated areas.

The patient was sent to the New York Cancer Hospital and was put upon the mixed toxins of erysipelas and bacillus prodigiosus. Within two weeks there was decided evidence of improvement, which continued slowly but steadily until the end of three months, when the growth had entirely disappeared. About a week after the injections had been suspended, the patient became suddenly infected with erysipelas in the unhealed portion of the ulcerated area where the tumor had sloughed out. The patient had a very severe attack of erysipelas, and on his recovery returned to his home in Canada. I personally examined him on the first of September in Toronto, and there was absolutely no trace of any return of the disease. I again heard from him in April, 1900, and he stated that he was in perfect health and engaged in his regular occupation as a farmer.

*Case* 2. *Rouna-cell sarcoma of the nose and antrum—partial success.*—J. M., age 42, colored; was referred to me by Dr.

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Wm. T. Bull, December 29, 1893, with the following history: One year before he noticed a filling up of the right nostril, and was treated for some time by a throat and nose specialist at one of the clinics, for a polypus. September 28th, 1898, he was operated upon at the New York Hospital, and as much of the tumor as possible removed. It grew again very rapidly after the operation, and when I first saw him it had reached the size of half an egg. The cavity of the right nostril was filled, there was marked bulging of the nose and some bulging of the antrum. He had frequent and severe hemorrhages. He was admitted to my service at the New York Cancer Hospital, January 9, 1899, and the toxins were given daily. Injections were made into the tumor and the doses increased to the point of causing three or four severe reactions a week followed by a temperature of 103° to 105°. The tumor diminished very markedly in size, the hemorrhages stopped, and portions of the tumor filling the nasal cavity sloughed out. With a view of increasing chances of success, a few weeks after the beginning of the treatment, I tied the right external carotid artery. The improvement continued until the middle of March, when there was almost no trace of the tumor remaining. The patient was sent home for two weeks; but during this interval the tumor began to increase in size. Although he was readmitted to the hospital and the treatment was resumed, we were never able to entirely control the disease. There was steadily although slow increase in size, until the fall of 1899, when the tumor grew with great rapidity, and the injections were stopped. The increase of growth was far more rapid after the cessation of the treatment, and he died not long afterward in another hospital, from shock and hemorrhage following operation of excision of the carotid arteries.

*Case* 3. *Recurrent sarcoma of the cheek, following trauma.*—Mrs. L., aged 40 years, was referred to me by Dr. C. M. Thomas of Spokane Falls, March 8th, 1898, with the following history. The patient was in good health until June, 1897, when she received a blow from a fist upon her left cheek. A swelling appeared at once at the site of the injury and never entirely, disappeared. After a few weeks it began to grow slowly, and seemed to be situated between the skin and the mucous membrane. On February 4th, 1898, it had reached the size of half a hen's egg, when it was removed by Dr. Thomas.

The patient thinks it did not again recur until about November, 1898 When I first saw her, March 8th, 1898, physical examination showed a cicatrix extending from the angle of the mouth on left side backward 2½ inches.

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There was a hard tumor ¾ an inch in thickness and about 2 x 3 inches in area. The tumor was firm in consistence, and was situated between the skin and the mucous membrane. The mouth could be opened only ¾ of an inch, and she had not been able to wear her false teeth for several months.

Mixed toxins were begun at once at the New York Cancer Hospital and continued for six weeks, at the end of which time there was entire disappearance of the tumor. On March 3rd, 1899, I performed a plastic operation to improve the appearance of the mouth, because of the previous operations. I removed most of the old scar. Careful microscopic examination, made by Dr. Buxton, showed no evidence of sarcoma remaining. A few weeks later the patient complained of stinging pains on the site of the cicatrix, very similar to those she had noticed previously when the disease began to return, and there seemd to be a thickening in the scar. Injections were begun for a time and the pain disappeared. Shortly after this the patient returned to her home in British Columbia, and I am unable to give the later history.

There are other recent cases of interest that I could mention did the time permit. It is true that sufficient time has not elapsed in these particular cases to justify one in claiming them as permanent cures, and they are not mentioned for this purpose, but merely to furnish additional proof that the mixed toxins have a specific action upon sarcoma. That this action is permanent and curative in a large number of cases is proved by a brief reference to my earlier cases already reported. The later history of these cases is as follows:

*Case* 1. *Spindle-celled sarcoma of the neck and tonsil.*—Tumor entirely disappeared under injections of the living bouillon cultures of erysipelas, producing an attack of erysipelas. Patient well six years later when last heard from.

*Case* 3. *Spindle-celled sarcoma of the abdomial walls and pelvis.*—Mixed toxins administered Jan. 3, 1893. Tumor entirely disappeared. Patient alive and well at present, seven years later. This patient was exhibited before the Academy of Medicine, March 1, 1900.

*Case* 4. *Spindle-celled sarcoma of the abdominal walls.*—Pronounced inoperable by Dr. M. H. Richardson of Boston. Microscopical examination by Dr. Whitney, Pathologist to the Mass. General Hospital. Tumor entirely disappeared and the patient is now well, six years later.

*Case* 5. *Recurrent spindle-celled sarcoma of the popliteal space and leg.*—Tumor disappeared. Recurred one and a

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half years later. Amputation of the thigh. Recurrence in the gluteal region again treated with toxins; patient now well, six years after.

*Case 6. Inoperable epithelioma of the chin, lower jaw and floor of the mouth.*—Mixed toxins for three months. Growth disappeared. The patient was well when last heard from five years later. This patient was pronounced inoperable by Dr. George R. Fowler of Brooklyn, and the microscopical diagnosis made by Dr. Belcher, the pathologist of the Methodist-Episcopal Hospital.

*Case 24. Very large recurrent inoperable sarcoma of gluteal region treated* 1894.—Tumor slowly decreased in size and 5 years later there remained only a mass of pure fibrous tissue. Removed and examined microscopically. Patient in good condition 6 years later.

As to the risk attending the treatment, I believe that with the observance of proper precautions, it is nil or exceedingly slight. Including the early experiments in cases of carcinoma I have used the toxins in upward of 200 cases with but two deaths; both of which occurred more than four years ago. In estimating the percentage of cures it is well to remember that the treatment is advised only in cases of sarcoma in which there is no hope of cure from operation. In other words, in entirely hopeless cases. Of my series of cases, in a very large number treatment was begun after the disease had reached such an advanced stage that there was practically no hope of more than temporary improvement. To have saved even one case of inoperable cancer would seem quite sufficient to offset the disappointment of a hundred failures. If instead of one per cent there is a probability of being able to save upwards of 10 p. c. of these otherwise hopeless cases we certainly have sufficient encouragement to continue the method. I believe that the most promising field lies in the use of the toxins in small and safe doses directly after the primary operation, instead of waiting for a recurrence to appear. If the toxins can in a considerable number of cases destroy and permanently cure large inoperable sarcoma, it is reasonable to suppose that their administration after operation will destroy the invisible portions left behind, and thus in a much larger number of cases prevent subsequent recurrence.—*St. Paul Medical Journal*, June, 1900.

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# A CLINICAL STUDY OF HEROIN.

By JAMES R. L. DALY, M.D.
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A new agent in the treatment of cough, at present in wide use and attracting considerable attention in the medical world, is Heroin. It is a derivative of morphine—the diacetic acid ester—and is a white crystalline powder, almost insoluble in water, but readily soluble in water to which a few drops of acetic or hydrochloric acid have been added. It possesses many advantages over morphine as a respiratory sedative, among which the following may be mentioned: (1) It prolongs respiration, and at the same time increases the volume of each inspiration, making it a remedy much to be desired in the treatment of cough; (2) it is not an hypnotic; (3) absence of danger of acquiring the habit; (4) it does not weaken the respiratory apparatus; (5) it does not cause unpleasant disturbance of the stomach or intestines; (6) it can be prescribed in cases in which heart complications occur without risk of any deleterious effect upon that organ; (7) the ratio of the therapeutic dose to the toxic dose is considerably smaller than that of morphine.

The following cases taken at random from a clinical field of over 100 cases of pulmonary tuberculosis in all stages of the disease in this hospital will best serve to illustrate the efficacy of the drug:

CASE 1.—A. B., male, age thirty-two, clerk, entered hospital with history of pain in left side, which began about four months before admission; night sweats; hacking cough, most troublesome at night, with markedly diminished secretion and slight dyspnœa at varying intervals during day and night. Physical examination revealed consolidation of upper lobe on left side, and of apex on right side. Mist. codeia, one drachm, three times daily and at midnight was administered and continued for two weeks, but with little result. At the end of this period the codeine was stopped and Heroin substituted in doses of one-twelfth grain three times daily and at midnight. In four days the cough began to lose its hacking character, and the secretion became more abundant; in about one week the cough could only be observed in the morning and evening, and remained sufficiently loose to render the patient very comfortable. No dyspnœa was observed a week after the Heroin was begun, and breathing still remained free. Mean respiration during first twenty days in hospital, a.m., 29; p.m., 29 3-20. Mean respiration for twenty days following the first administration of Heroin, a. m., 24 6-20; p. m., 25 1-20. For the night sweats the

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patient was given a pill of zinc oxide, two grains, with extract belladonna, three-tenths grain, for three nights without result. On the third night Heroin was substituted for codeine, and on the second night following the sweats ceased.

CASE 2.—On admission the patient complained of severe and painful cough throughout the day and night; expectoration scanty, and obtained only after considerable effort. Physical examination showed both lungs involved with cavity in right middle lobe. The patient was given Heroin, one-twelfth grain, three times daily at first, and shortly after the dose was increased to one-sixth grain. After one week of Heroin the cough was diminished to a marked extent, and the pain heretofore associated with the cough had disappeared.

CASE 3.—Patient entered hospital complaining of "smothering sensation" in chest, with slight pain. Heroin, one-twelfth grain, three times daily and at midnight, was administered, and in three days this "smothering" had disappeared, but not permanently, as the patient has since complained of it; but he says that it is not as severe or as lasting as before he was put on Heroin. Of course, the cough which was present was greatly loosened, and this it was that gave the patient relief.

CASE 4—Patient entered hospital complaining of hard, dry and persistent cough, most troublesome towards evening. Expectoration scanty, and effort of coughing caused great pain in chest. The patient was given Heroin, one-twelfth grain, and in three days the cough became soft, and expectoration became quite free. The pain in the chest had, of course, disappeared with the hard cough. The patient remained very comfortable for a month, when Heroin was discontinued, because I believed it to be the cause of a certain heavy feeling of which he complained. The cough, however, again became severe and hard, and Heroin was repeated in the same dose as before. In three days the patient was freed from the distressing cough, and that "heaviness" has not returned. Mean respiration during period in which the patient was taking Heroin, a. m., 24; p. m., 26. Respiration became more rapid while the patient was without the drug, averaging, a. m., 25 3·14; p. m., 27 11-14.

CASE 5.—Patient has been in hospital for some time. Complained of severe cough beginning about midnight and lasting until morning. Heroin, one-sixth grain, was administered every night at 10.30. The cough was absent on second night that Heroin was administered, and has not since distressed the patient.

CASE 6.—Patient complained of severe night sweats, and

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was given atropine, 1-100 grain, for two nights without success; on the third night Heroin, one-sixth grain, was given one-half hour after atropine, and sweats ceased.

CASE 7.—J. F., male, age thirty-two, laborer. If any case can be said to be a striking example of the efficacy of a remedy, this case is certainly that one. The patient entered the hospital with very slight but hard cough and a history of marked and constant night sweats. The latter had inconvenienced the patient for seven weeks previous to entrance, without an intermission of a single night. Mis. codeia, one drachm, three times daily, was administered for the cough, and an attempt was at once made to check the night sweats. Camphoric acid had been a favorite with me in the treatment of this symptom, and I accordingly gave 20 grains at bed-time, and repeated the same dose for four succeeding nights, but without result. Then atropine sulph. and ac. sulphuric aromat. were tried in the proportion of one-fiftieth of the former and 10 minims of the latter, but again without a favorable result. This was given for five nights. Atropine sulph. alone was tried in dose of one-fiftieth grain for a week; still no response. Next was tried a pill of zinc oxide, two grains, and extract belladonna, three-tenths grain, for five nights, and this, like the rest, failed. Pilocarpine was next tried in dose of 1-100 grain, but it only increased the sweating. Next in order came warm baths, and then bathing with ac. sulphuric dilute, but these met the same fate as all the preceding. Then I decided to give the sweat glands a rest, and for a week nothing was administered for the sweating, and at the end of this time atropine sulph. was repeated in doses of one-fiftieth grain, but without result, until about the fifth night of the administration of the latter the codeia mixture was discontinued and Heroin substituted in dose of one-twelfth grain three times daily. On the third night of the administration of the latter the sweats decreased to a great extent, and on the fourth night ceased altogether. The Heroin had replaced the codeia mist., not because of the sweating, but because of the hard cough, which did not improve; and since the patient had been taking the former the cough has loosened considerably, and he now experiences marked relief. I regard this case as typical, not of the curative effects of Heroin on the night sweats, but rather of the quality of the drug to assist the ordinary anhydrotics when, given alone, they fail.

CASE 8.—Case of tubercular laryngitis. Patient complained of severe sore throat, which prevented deglutition. Pills of Heroin, one-twelfth grain, were administered every

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three hours, and kept the throat in a condition of anesthesia for about one to two hours, rendering the patient fairly comfortable, and most of the time free from pain. It is unnecessary for me to mention that the patient was instructed to dissolve the pill slowly on his tongue. Two other marked cases of tubercular laryngitis were temporarily relieved by the administration of Heroin in this manner.

These cases are fair samples of the results obtained by the administration of Heroin. In almost every case in which it has been tried it has been of some service in the alleviation of cough, be that service ever so slight. Even the advanced cases have been to a certain extent relieved. I found, however, that the more favorable results were obtained in those cases in which the disease process had not advanced to too great an extent. In this class of cases the drug never failed to loosen a hard cough and produce free expectoration, giving marked relief from pain when present. I regard it as unequalled as a sedative in the treatment of cough of pulmonary tuberculosis, and venture to say, although I have not tested it in cases of cough in other pulmonary affections, that it will act equally well in such cases.

The smaller dose of one-twelfth grain is sufficient to afford relief in most cases, certainly in the milder or earlier one, but in some instances it was found necessary to increase the dose to one-sixth grain, as after a time the smaller dose seemed to lose its effect upon the patient. Sometimes when Heroin had been taken for a long time, it was found to be a good practice to stop it and give codeine, or some other sedative, for one week, and then renew the Heroin at the end of this time. In this way the drug acted as well when renewed as in the beginning of the treatment. It is true, however, that Heroin produces its effect for a much longer period than does any of the other sedatives used in this affection.

I said it was not a hypnotic, but the fact that it relieves the distressing cough which is often the cause of many sleepless nights, and thus ensures a natural sleep, obviating the necessity of using hypnotics, should not be over-looked.

I have very carefully watched the temperature charts for any evidence of its action as an antipyritic, but have been unable to find that it produces any effect whatever on the temperature. It certainly possesses no quality as a preventive or cure of the chills so persistently present in the later stages of tuberculosis. Like the respiration, the pulse is rendered fuller and slower. In 10 cases observed the mean pulse rate was reduced about four beats per minute; in one case the rate was reduced eight beats per minute. By its action upon

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respiration and its ability to relieve cough and promote excretion of secretory products, it manifests a decided effect upon the dyspnea.

I regard the influence of Heroin on the night sweats as second only in importance to its influence as a sedative for the cough. In the cases cited its quality as an adjuvant to the ordinary remedies in checking the sweats is well marked. In six other cases favorable results were obtained in either checking or markedly decreasing the sweat by the administration of Heroin in conjunction with one or another of the ordinary anhydrotics. Its action in this particular is best appreciated after meeting failure in using the ordinary agents alone.

The cases of tubercular laryngitis mentioned are typical of its action as an analgesic in the treatment of the painful throats of this affection. In these cases it afforded considerable relief from pain for periods of about one to two hours following the administration of the pill.

In regard to its influence on respiration, I have carefully noted 19 cases, and have found that in each case the mean respiration a. m. and p. m. has been reduced from two to five, and in some cases as high as seven per minute.

No action in the intestines was observed, except, perhaps, a slight tendency to constipate if given in larger doses than one twelfth grain. Of this, however, I will not be certain, as in the great majority of cases this action was not apparent. In some cases it has been noticed to cause a disturbance of the stomach. One patient complained that the drug caused considerable nausea shortly after taking, while with others the disturbance can best be described by using a term applied by a patient to the condition of his stomach after taking Heroin—"squeamish." One complained of complete loss of appetite whenever he took the drug. In all, some disturbance was noted in five cases out of upwards of 70 patients taking the drug. I should add however, that two of those who complained of disturbance of the stomach while taking Heroin were later able to use it without noticing any ill effects. Another, and, in my opinion, the only real objection to Heroin, is that in certain cases the larger dose of one-sixth grain was found to cause a feeling of heaviness during the day. To quote a patient, "I feel heavy and as though I want to sleep, but if I tried to do so I find that I cannot." This was observed in four cases. The drug did not in any instance produce this effect when given in the smaller dose. But the chief use to which Heroin can be put is as a sedative for the cough and to prevent the distressing

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and disagreeable stagnation of secretory products in the lungs, particularly in cases of pulmonary tuberculosis. No drug can compare with Heroin in this particular. Cases that have come into the hospital with painful and almost constant cough, with inability to raise the sputum, resulting in fetid breath and more or less dyspnea, have been almost immediately relieved of pain, and the expectoration rendered freer, with decrease in the dyspnea, by the administration of Heroin in doses of one-twelfth grain three times daily.—*Boston Medical and Surgical Journal*, February 22, 1900.

# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

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### SERUM DIAGNOSIS OF TYPHOID FEVER.

William G. Savage, in the *Clinical Journal* of May 2, 1900, says that the so-called Widal test depends upon the clumping and cessation of movement in a broth culture of the typhoid bacillus when seen in a hanging drop. We cannot say in every case where clumping or cessation of movement occurs that the patient from whom the blood was taken is suffering from typhoid fever. Sometimes the bacillus typhosus in a broth culture will clump spontaneously. This source of error is easily eliminated by examining the culture before the serum is added. The cause of this spontaneous clumping is not known. Another source of error is where an examination is being made for suspected typhoid and the disease may be either influenza, anemia, or some other condition easily confounded with it. In such cases the patient may have had typhoid fever years before. It is claimed that the Widal test may be obtained years after the infection. Errors in such cases are difficult to avoid.

Normal serum, if diluted slightly, say one in ten, may in certain cases cause some clumping. If the serum be further diluted and again examined with typhoid broth, these changes do not take place. The writer believes that if the serum be sufficiently diluted, clumping with normal blood never takes places. A dilution of one in thirty or one in fifty, or even higher, is necessary to prevent failures from

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this source. The sera of diseases other than typhoid are cited by some writers to give positive reaction. Cabot points out that scarcely any two observers find these pseudo-reactions in the same diseases, and in all probability, with a careful technique and perfect dilution of the serum, they never take place.

The blood in enteric fever does not always give a characteristic reaction. This may be divided into three classes: (*a*) The test may be made too early in the course of the disease; the reaction is generally obtained about the end of the first week. (*b*) There are cases in which the reaction is known to intermit; for example, it is present one day, absent the next, and again present the next day or in a few days. These cases are probably very infrequent and do not seem to be a common cause of error. (*c*) A few cases of proven enteric fever yield no serum reaction throughout the disease.

The first two causes of absence of reaction obviously teach that in negative cases we should repeat the examination of the blood at a subsequent date. A negative reaction, though not so valuable as a positive one, is yet of great value. Efficiently performed, the test is correct in from 90 to 95 per cent of the cases.

In collecting the blood for making an examination, it may be done by allowing a drop to dry on a glass slide, or it may be drawn into a capillary pipette and the ends sealed. The latter permits of the serum being separated from the blood without the admixture of corpuscles thus making it somewhat more accurate. If the dried blood is used it is mixed with a little water of inert fluid, and a small quantity is taken up in a loop.

Care should be taken in obtaining the typhoid bacillus, as those which have a tendency to clump spontaneously are valueless. Some cultures of the typhoid bacillus give a prompt reaction and others do not. The author describes one case in which the test was made with four different cultures of the typhoid bacillus. In one a well marked reaction was obtained, in another it was doubtful, and in the remaining two there was no reaction. He uses a culture of agar from two to six weeks old kept at room temperature. From this a tube of sterile broth is inoculated and grown at 37° C. This culture should not be more than twenty-four hours old if grown at a high temperature.

The serum diagnosis of typhoid may be carried out without the aid of a microscope, by what is known as a sedimentation method. This, by some writers, is considered even

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more valuable than the microscopic test, and is performed by diluting the serum, which for this purpose must be obtained in capillary tubes with twenty-four parts of normal saline solution, and then added to equal parts of a fresh broth culture of the bacillus typhosus. If at the end of twenty-four hours the solution shows a uniform turbidity, the reaction is negative. If, on the other hand, well marked plugs are seen at the bottom of the fluid or along the sides of the tube, the reaction is positive. The method requires no watching, but performs itself.

## BICHLORIDE BATHS IN THE TREATMENT OF VARIOLA.

H. A. Ingalls (*Journal of the American Medical Association*, April 28, 1900) has treated thirty-six cases of variola, of which one was hemorrhagic and thirteen confluent, without mortality, by means of these baths. The first case was seen in the papulovesicular stage, of confluent type. It was noted that the pustulation and pitting were much less than might have been expected in so severe a case. The baths were comforting, and there was but a trace of the peculiar odor of the disease. The method of giving the baths was to take a six-foot tub which was filled with fairly warm solution of the bichloride, 1-to-10,000. The temperature ranged from 103° to 105° F. The patient was placed in the tub and rubbed with a soft cloth, the bath lasting from ten to twelve minutes. After removal from the bath patients commonly expressed much relief, but shortly after, owing to the drying off, complained of a burning sensation, which led to a routine practice of anointing the patients after a bath with a mixture of subnitrate of bismuth, carbolic acid, and olive oil.

## COLD IN THE HEAD.

Dr. A. S. Barnes, in the *Interstate Med. Jour.*, says that a quick method to cure a cold in the head consists in a hot bath and warm bed; one-eighth of a grain of pilocarpine muriate is then administered, and, after three-quarters of an hour of sweating, one one-hundredth grain of atropine is taken. This is followed by a prescription containing phenacetine, salol and caffeine citrate at intervals of two hours.

## CHRONIC CONSTIPATION IN CHILDHOOD.

Heinrich Dœrfler has, for the last six years, met with flattering success in the treatment of chronic constipation

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in children by the administration of butter. It should be fresh, and of the best quality. It should be given in the natural state, and not by means of any vehicle. For the first month clysmata may be given; in the second and third month from a half to a whole coffeespoonful of butter daily morning and evening, till the stools are normal; then only every two days. The dose is further increased according to the age.—*Medical Record.*

## PRURITIS ANI.

An injection of ergot, hydrastis and carbolized oil of two drachms into the rectum is given first. If the skin is hard it is painted with a saturated solution of silver nitrate every third day for three visits. Then every day citrine ointment is used and bound on with a cotton pad. The itching at night may be relieved by extremely hot water, followed by black ointment or calomel salve, being careful not to scratch the skin. This daily routine is followed for six weeks, then at longer intervals for six months, never stopping in less time, but occasionally going longer. Of two hundred cases thus treated, permanent cure resulted in every case, many cases having been observed for five years. As the author considers the lithic acid diathesis a prominent constitutional cause, this must receive internal medication and the bowels must be moved every day.—*Phil. Med. Jour.*

## ON THE CARE OF ARTIFICIAL TEETH.

The fortunate possessor of a healthy olfactory nerve must have frequently observed the peculiarly offensive breath found only in those who wear a toothplate. By a little care and proper management, this trouble may be avoided. It goes without saying that no one can enjoy ideal health while compelled to breathe foul air, whether the cause be extrinsic or intrinsic. There *are* dentists who advise their patients to never remove the plate from the mouth except long enough to clean the teeth after eating. But most of them, I think, will say that in the vast majority of cases it is not necessary to wear them during sleep, at which time they should usually be kept in pure water, to which, if desired, a little salt may be added.

It will thus be found practicable to keep the teeth free from a bad odor, and the mucous membrane of the mouth in a healthy condition. After each meal, if convenient, water at near the boiling point, should be gradually poured upon the teeth and allowed to remain until sufficiently cool to

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permit the use of a brush. The dark stain which comes upon the teeth and the rubber plate may be removed by a ten per cent solution of chemically pure nitric acid, or by pumice. After eating meat, care should be used to remove every particle which may have found its way into the interstices.—*Med. Times.*

## SIMPLE TREATMENT FOR PERSISTENT VOMITING.

Dr. Mitchell states that he has succeeded frequently in overcoming persistent vomiting by the aid of cold compresses. The method he uses is to wring towels out of ice water and to change them every minute until the vomiting ceases. It takes from fifteen to twenty minutes to stop the vomiting.—*Medical Summary.*

## TO CONTROL HIGH TEMPERATURES.

Dr. C. C. Booth (*Phil. Med. Jour.*) suggests the following method of reducing a high temperature: "The patient is stripped entirely of all clothing, placed upon rubber sheet and covered with one thickness of a piece of cheese-cloth two yards long and the usual width, one end having been split so that each leg can be covered separately. A nurse is directed to squeeze water at about the temperature of the body from a sponge, over the entire anterior surface of the body, and to wet the gauze freely as often as necessary to supply the water for evaporation. A case of typhoid fever, with persistent high temperature, is reported, in which this method was used. From the beginning of treatment the pulse, nervous system, temperature, strength, and every symptom rapidly improved. The idea originated upon observing the depression of the wet bulb of a wet and dry bulb hygrometer caused by the evaporation of the water from the gauze, which is applied tightly to the bulb containing the mercury. All that is claimed for this method is that it is more convenient, more easily applied, less dangerous, cheaper and pleasanter to the patient than any other method. The gauze is to be kept wet until the temperature is reduced to normal."

## NIGHT SWEATS.

Few practitioners appreciate the exceedingly great value of agaricin as a remedy in night sweats, especially those of phthisis. The most profuse sweat is checked almost by magic, with a single dose. It operates by diminishing thirst and increasing the secretion of urine. The dose may be pushed

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to the extent of one grain in the course of twenty-four hours. The single dose for an adult is from one-eighth to one-fourth of a grain.—*Technics.*

## INFANTILE CONVULSIONS.

Dr. R. S. Roland, of Sylvain, Tex., says the physician is seldom called to a case until the child has had one or more convulsions, and is often in the dark as to the cause; however, the general treatment is about the same in all cases. If they are due to some pathological state, special treatment should be directed to it.

Now, when called to a case, do not spend too much time trying to get at the cause, but go right to work. Place lower extremities in hot mustard water, or give a general warm bath from five to fifteen minutes, according to the severity of attack, with cold to the head; give an enema of soap and water. Syrup of ipecac as an emetic if something indigestible has been taken recently; bromide of potassium and chloral hydrate, according to age, every ten minutes until the convulsions cease. In those subject to attacks their hygienic surroundings should be the best.—*Medical Summary.*

## PAIN.

Pain of a neuralgic or drawing character in the neighborhood of the heart is found as the result of several causes, as a rule, in the following order of frequency:

1. Pain with palpitation of the heart from the accumulation of flatus in the transverse colon just as it turns to descend. Many patients who go to the physician complaining of heart disease suffer only from this condition, due to fermentation in the large bowel. Again, the pain due to gastralgia, or, as it has been called, cardialgia, may be referred to the heart by the patient.

2. Intercostal neuralgia due to debility. In these cases tender spots will often be found, one in the precordium, another in the outer edge of the scapula, and a third on the vertebral column. These are sometimes called "spots of Valleix." In other cases the pain will be due to spinal trouble, anemia, or tight lacing of corsets.

3. Pseudo-angina.

4. True angina.

5. Locomotor ataxia.—H. A. Hare, in *Practical Diagnosis.*

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## AIDS TO DIGESTION.

By lying on the right side for fifteen minutes after a meal all the liquid would gravitate out, leaving the solids to be acted upon by the gastric juices. Also, that when the bile flowed back into the stomach producing vomiting, taking the recumbent position on the right side would soon stop the vomiting. The rule of lying on the right side for fifteen minutes after each meal is one of the best treatments for dyspepsia. Again, before rising in the morning one should lie a half hour on the left side, thus emptying the colon. In dysentery and diarrhea one should immediately, after each passage, lie down down on the right side. As soon as it is necessary again to evacuate the bowel, then turn on the left side a moment before rising. Thus we will prevent accumulations in the lower bowel that produces tenesmus. When the bile becomes very acrid, and the digested products fermenting instead of the usual healthy products, this matter parboils and inflames the intestine, and more especially the colon where the small intestine is attached; therefore, by freeing the colon, flushing it, the cause is removed and the inflammation subsides and the "appendicitis" gets well. Gravity, water and common sense are wonderful doctors.—*Med. Visitor.*

## NASAL OBSTRUCTION.

The *Medical Age* says: F. R. Reynolds states that by the successful treatment and permanent relief of nasal stenosis many diseases are prevented, relieved, or cured, Among these are anemia, marasmus, hay-fever, asthma and laryngismus stridulus. Reflex cough may be due to hypertrophic rhinitis. Also, gastralgia, cardiac palpitation, neuralgia of the trigeminus, scotoma, migraine, cephalalgia, ciliary neuralgia, vertigo, photophobia, neurasthenia, spasmodic cough, spasm of the glottis, frontal and supra-orbital headache may all have their origin in an exciting nasal focus. Emphysema and bronchitis often accompany nasal stenosis. Nasal stenosis not rarely has a deleterious effect on the ears.

## INFANTILE SCURVY.

There are two affections occurring in children for which scurvy is particularly mistaken; acute rheumatism and acute anterior poliomyelitis. There is practically no reason at all why scurvy should be confounded with the latter disease. There is, of course, absence of movement in the limbs in both

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cases, but in anterior poliomyelitis this is due to inability to move them because of palsy; in scurvy the failure of movement is due to pain. This can very easily be decided by passive movements. Scurvy and acute rheumatism are not so easy to differentiate. In scurvy, however, the hemorrhage is not into the joint and not into the epiphysis, but practically always into the diaphysis of the long bones. Blood extravasations occur at times over the tissue and occasionally even over the carpus, but these are rare exceptions. If the bones are protected from motion, it will be found that the joints in scurvy may be freely moved. At times, in scurvy, hemorrhage occurs into the joints, and this may almost hopelessly confound the disease with rheumatism; but these joint hemorrhages are very rare.—A. JACOBI, *Medical News.*

## INTESTINAL REST IN TYPHOID.

### IT IS AN AXIOMATIC PRINCIPLE IN BOTH SURGERY AND MEDICINE THAT A CONGESTED OR INFLAMED PART NEEDS REST.

The surgeon recognizes this when he immobilizes the fractured bone and retains the fragments in apposition; the physician likewise appreciates the great importance of this principle in cases of gastric ulcer when he feeds his patient by the rectum in order to avoid irritating the inflamed part, either directly, or by exciting gastric motility. Although typhoid fever is essentially a systemic disease, its characteristic local lesion is the intestinal ulcer, which should, as far as possible, be *kept at rest.* Milk, which has heretofore been regarded as the only proper exclusive food, is, as a recent writer says," not a liquid diet, but a deceptive solid" —capable of filling the small intestines with dense indigestible curds which scratch and irritate the ulcerated bowel, and in addition, ferment and cause gaseous distention, tympanitis, etc. *Liquid Peptonoids*, on the other hand, is open to none of these objections. Its administration *affords rest* to the ulcerated intestinal tract, because :

1st. *It is pre-digested,* and therefore promptly absorbed from the stomach, leaving no residue for the bowel to dispose of.

2nd. *No curds* are formed as from milk.

3rd. *It is absolutely aseptic* and cannot cause fermentation, tympanitis or increased peristalsis, resulting in diarrhea.

4th. *It has the requisite nutritive power* to maintain life for weeks and even months, especially in febrile conditions.

Another advantage of *Liquid Peptonoids* is its *pal-*

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*atability*, which renders it grateful to the patient, especially when given ice cold.

From one to two tablespoonfuls every two, three or four hours, should be given as necessary. When an efficient intestinal antiseptic is required, as it very frequently is in this disease, *Liquid Peptonoids with Creosote* provides both food and remedy at one and the same time. The unpleasant taste of the Creosote is almost entirely abolished in this combination. Each tablespoonful contains two minims of pure beechwood creosote and one minim of guaiacol, its active principle.

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# SURGERY.

IN CHARGE OF

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AND

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## FRACTURES OF THE ANKLE.

There are three little practical points of importance to be emphasized in connection with the treatment of fracture of the ankle: *First*, whatever other precautions may be taken in the treatment of this fracture to obtain a good result, one should always place the foot at a little less than a right angle. *Second*, in case of a painful joint following Pott's fracture, the foot should be fixed for a period of about six weeks at a little less than a right angle, the patient being permitted to walk without the use of a crutch. *Third*, this can easily be accomplished by applying the plaster-of-paris cast with the knee in a flexed position.

If these practical points are observed, fractured ankles are not painful after the fracture has healed, and those which are painful after other methods of treatment will be free from pain in a few weeks, notwithstanding the fact that they may have resisted the ordinary forms of treatment for weeks, or months, or even years.—A. J. OCHSNER (*Amer. Jour. of Surg. and Gynec.*)

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## THE TREATMENT OF WENS BY THE INJECTION OF ETHER.

Emile Sergent, Paris, has used injections of ether into wens with good results. The quantity to be injected varies with the size of the tumor. If the patient complains of pain the syringe may be detached from the needle for a few minutes, then reattached and more ether injected. Four or five injections, every other day, always the same site, will be followed by liquefaction and the contents may be expressed. The sac will become less adherent; the few adhesions remaining may be broken up by introducing a stylet through the small original wound and the sac then slowly drawn out. Dr. Sergent claims these advantages for his method. It is not painful, not bloody, not dangerous, is easy to do and leaves no scars. The latter is an especial advantage where the wen is situated upon the face.—*La Presse Med., St. Louis Medical Review,*

## FISTULA IN ANO; ITS RELATION TO PHTHISIS.

S. G. GANT, New York, concludes his discussion of the subject with the following observations, which summarize his views: (1) Tuberculous fistula of the anus is usually secondary to tuberculous disease of the lungs. (2) Pulmonary phthisis is rarely, if ever, secondary to fistula in ano, either before or after operation. (3) Tuberculosis of the anal region should be dealt with radically, as is recommended when it attacks other parts. (4) When the patient's general condition will permit, we should operate on all fistulæ, irrespective of the kind. (5) We should not refuse to operate on persons suffering from a mild form of phthisis, nor on those who give a family history of tuberculosis. Certainly, if we arrest one destructive process, nature is all the more capable of dealing with the other. (6) Those patients operated upon for tuberculous fistula and those that are non-tuberculous complicated by phthisis, who rapidly decline and die, do so as the result of an inflammation of the lungs induced by the anesthetic, especially ether. Such accidents have not followed any of the operations which the writer has performed under local anesthesia. (7) He believes that we are justified in discarding the erroneous teachings of writers who believe that the cure of a fistula will result in a development of phthisis.—*N. Y. Med. Record.*

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## FORMALIN AS AN ANTISEPTIC IN GENERAL SURGERY, GYNECOLOGY AND OBSTETRICS.

G. E. CRAWFORD, Cedar Rapids, Io., is convinced from his own experience that formalin, the 40-per-cent. solution of formaldehyd, comes nearer meeting all the requirements of a perfect disinfectant than any other substance yet employed. Its germicidal potency ranks with that of the two or three most efficient bactericides, and its inhibiting power is probably greater and more lasting than that of any of them. It is not only an antiseptic, but a deodorizer as well, and solutions of potent strength are much less irritating, both to the hands and to wounds, than any other equally efficient antiseptic. It is not injurious to instruments and it is practically innocuous. Large cavities can be freely irrigated, even the peritoneal cavity, and a considerable quantity of the solution can be allowed to remain without injury or danger of toxic effect. The solutions that have generally been recommended are too strong. The strength of a solution depends upon the amount of formaldehyd it contains, and it should be remembered that this is two and a half times stronger than formalin. The latter is a definite substance, and is the tangible form in which we employ formaldehyd as an antiseptic in surgery; therefore the percentage of a given solution should be that of formalin and not that of formaldehyd. The solutions of formalin commonly used are the eighth, fourth, and the half per cent.; the two former for washing infected wounds and irrigating and packing cavities and sinuses, and the latter for disinfecting the hands and the surface of the body. They contain formaldehyd in the strength of one two-thousandth, one one-thousandth, and one five-hundredth respectively. The half per cent. solution is of about the right strength for the hands. In gynecologic practice, formalin is extremely useful; the peritoneal cavity can be freely irrigated with the one two-thousandth solution in cases of pelvis abscess, pyosalpinx, etc., where purulent matter has escaped into the cavity. It is superior to iodoform in packing and drainage of sinuses, while in obstetric practice it meets all the requirements of an antiseptic to disinfect the hands and the external parts.—*N. Y. Med. Jour., St. Louis Med. Review.*

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## INGROWING TOE-NAIL.

The following treatment is very strongly recommended by Dr. Kinsman in the *Columbus Medical Journal*;

1. Remove all pressure from the nail by cutting away a piece of the shoe.

2. Disinfect with hydrogen dioxide until no more "foam" appears.

3. Apply a drop of soft solution of cocaine in the base of the ulcer.

4. Apply a drop of Monsell's solution in the ulcer, then cover loosely with gauze. Repeat this process every second day until the edge of the nail is released by the retraction of the hypertrophied tissue. The patient suffers no pain from the application, and all pain has disappeared the second day. The cure is effected in a week or two without inconvenience or interference with business.—*Texas Medical News*, July, 1900.

## STRANGULATED HERNIA IN CHILDREN.

Coley, W. B. (*The Journal of the American Medical Association*, Vol. xxxiv., No. 6) says:—

Strangulated inguinal hernia in infants and children is not so rare as might be supposed. He has operated on eight patients under two years of age, with one death. The fatal case was in an infant of eight weeks who was moribund at the time of operation.

In four of the cases the sac contained cecum, and in three of these four the appendix was also found. The author believes that, as a rule, the neck of the sac is not the cause of the constriction. With scarcely an exception herniotomy may be supplemented by an attempt at a radical cure.

The diagnosis of strangulated hernia in children is not usually difficult, though it may be confined with hydrocele of the cord.

Gentle taxis for two or three minutes may be tried. If, after a second attempt to reduce the hernia has been made by taxis, preceded by the application of hot cloths, there is no result, the operation should be done without further delay. Temporizing is often the cause of death.

## TREATMENT OF FRACTURES OF THE PATELLA.

Dr. Will H. Means (*Columbia Medical Journal*) offers the following conclusions to an interesting article: 1. The

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results of a non-operative treatment are unsatisfactory both as to long confinement and functional disability. 2. The methods of maintaining apposition of the fragments by external appliances are unsatisfactory and unscientific. 3. In open arthrotomy the fragments can be carefully approximated and sutured in such a manner as will maintain apposition and, ultimately, bony union. 4. The operative method saves months of confinement, and gives permanent results. 5. The buried suture material should be absorbable, such as catgut or kangaroo tendon. 6. The field of operation should be continuously irrigated with a hot salt solution during the manipulation, and the incision closed without drainage. 7. The massage treatment begun at an early date is an important factor in restoring functional activity of the joint.

---

# OBSTETRICS.

IN CHARGE OF

H. L. REDDY, M.D., L. R. C. P., London,

Professor of Obstetrics, University of Bishop's College; Physician Accoucheur Women's Hospital; Physician to the Western Hospital.

## MANAGEMENT OF PUERPERAL INFECTION.

F. W. Sears states that we are often called upon to attend patients when the system has been severely taxed by the amount of poisons absorbed from the products of putrifaction, and it is our purpose to arrest this absorption by the safest and the quickest way. The finger or fingers of the physician passed into the uterus to remove portions too large to be washed away, or to serve as a guide to their removal by a pair of small placental forceps, and this followed by a thorough intra-uterine irrigation with sterilized water, or any other aseptic non-irritating solution will most effectually stop the absorption. If, after repeated irrigations, we fail to relieve the symptoms, we may find it necessary to resort to the curette, and this should be done carefully and thoroughly, remembering also that there is danger of perforation, and, if any septic material is left, an increased absorption. After curetting, the uterus should be irrigated and packed with gauze. If there is a sudden rise of temperature, the gauze should be removed and the uterus irrigated. In septic cases he believes that the curette is contra-indicated. Here fre-

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quent irrigations with a safe antiseptic solution should be our main local treatment. In giving a uterine douche, Sears prefers an ordinary curved glass irrigator.—*Am. Jour. Obstet.*

## PUERPERAL MASTITIS.

Brouha reports such a case on account of its occurrence at a period soon after labour. The first symptoms were noticed within twelve hours after delivery and before the child had been nursed. No causative lesion of the breast could be found, and no infection of the genital tract was present. The writer attributes the mastitis to the efforts before labour to obtain perfect cleanliness of the nipples, during which the germs may have entered the breast through some slight solution of continuity of its surface.

## PAIN AS A PATHOGNOMONIC SYMPTOM OF ECTOPIC PREGNANCY.

Henry C. Coe states that pain alone, when not accompanied by a clear history of menstrual irregularity, symptoms of pregnancy and the presence of a tumor at the side of the uterus or in Douglas' pouch known to be of recent development, is pathognomonic of extra uterine pregnancy only under certain conditions, viz.: The pain is of a sharp colicky character, distinctly localised on one side, attended with fainting more or less marked, and is usually followed by intervals of hours or days of complete remission. The pulse is accelerated during the attacks, and there is no rise of temperature. The latter is an important symptom, distinguishing ectopic from inflammatory conditions. The violent tearing pain attending intraperitoneal rupture is accompanied by the unmistakable evidence of internal hemorrhage. In extraperitoneal rupture the symptoms vary in severity according to the amount of blood lost, but soon subside, being succeeded by the usual evidences of pressure resulting from a mass in the folds of the broad ligament which dispels or displaces the pelvic organs. A persistent pain following the acute attack may indicate localised peritonitis.

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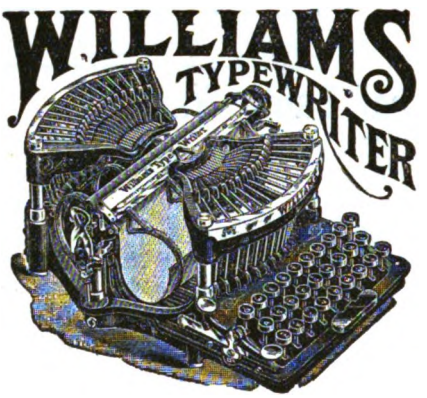


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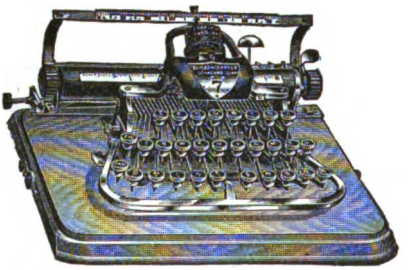

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THE
# CANADA MEDICAL RECORD

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# Editorial.

## GUN-SHOT ABDOMINAL WOUNDS.

The present South Africa war is rich in surgical lessons, but none are more striking and unexpected than that which has reference to gun-shot wounds of the abdomen. Even as late as the meeting of the British Medical Association held last summer, the consensus of opinion seemed to be "that even if the most remote chance of wound of the gut existed, the abdomen should be opened at the earliest possible moment." With this opinion, so to speak, ringing in their ears, the members of the Royal Army Medical Corps went to the war determined to avail themselves of every possible opportunity to deal scientifically with this class of wounds. This war seemed likely to present opportunities, such as had never occurred before, to practice modern abdominal surgery. But, very early in the campaign, it was recognized that such anticipations were not justified by results. Sir William MacCormac, Mr. Treeves and others who have world-wide reputations as surgeons, tell us that such anticipations were not realized, and that just the contrary was their experience. Water was scarce, and what was obtainable was abominable, filthy and impossible to make pure. By reason of this want, also that of towels and of many other needed articles, by

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reason of the plague of flies, and the want of sufficient help, an ideal aseptic operation was found absolutely impossible.

But even supposing that they had been available, there was found wanting the opportunity to attend such cases at the precise moment opportunate to possible success. After an engagement, the wounded were brought in, in such immense numbers that it was found an absolute impossibility to postpone attendance upon them that a few abdominal wounds might be attended to with that precision which a prolonged operation requires. At first this seemed to be viewed by the Medical Officers with deep regret. As time wore on, however, this regret seems to have turned into rejoicing, for subsequent experience has shown that operation for gun shot wounds is seldom needed. In the few cases where an operation was performed, it was clear that the puncture made by the bullet was small—so insignificant that it was very difficult to recognize, especially after the lapse of a very few hours, and that leaking had not occurred to any appreciable extent. It was soon recognized that the wound of a Mauser bullet was entirely different from anything previously met with. The wound was found to be so small that one, or, at most, two, Lembert sutures was sufficient to close them. It was also noted that extravasation of the contents did not occur, either because of the "ponting" of the mucous membrane or because the gut was motionless. More than one medical officer has suggested that this condition is due to the impact of the swiftly moving bullet inhibiting the peristaltic movement, or, as it were, "stunning" the intestine. The bowel wound was found to close rapidly, and the general opinion seems to be held that this especially occurred where the patient had been long without food, many of these cases being in men who had had little or no food for a considerable time. In fact, it has been found that the majority of abdominal gun-shot wounds were best treated by the expectant method, and under such treatment it is estimated that fully sixty per cent. recovered. Final deductions are, of course, as yet out of order, but Mr. Treeves has expressed the opinion that "most cases of wound below the umbilicus do well if left alone."

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It has seldom happened—possibly never before—that any steamship on a single trip has had its passengers exclusively composed of medical men. Yet this occurred when the magnificent steamship "City of Rome" sailed out of New York on the 30th of June, with three hundred medical men, many having with them their wives and members of their families. This large party was organized by three physicians. It was intended to make a tour of Scotland, England, Germany and Switzerland, before reaching Paris, where as many as desired could attend the International Medical Congress. The trip was to last thirty-eight days and cost $260.00, including hotel expenses, carriage fares, and all necessary fees for sight-seeing. We feel sure the party was a jolly one and that a good time was enjoyed by all.

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We congratulate our contemporary, the *L'Union Medicale*, on its greatly improved appearance. To-day it is not excelled by any medical journal in Canada in its outward look, and its contents bear a most favorable comparison with any. Long may it live and flourish, a monument of the rapidly advancing status of the Canadian medical profession.

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## TREATMENT OF INOPERABLE CANCER.

We publish, as a selected paper in this issue of the RECORD, an article on the treatment of Inoperable Cancer, by Dr. Colley, of New York. It is of very great importance, in view of the fact, admitted on all sides, that the last few years has seen a marked increase of this disease. Owing to our limited space we have cut out a number of the reports of the newer cases treated, as well as some of those recording the further results in the cases first reported. Sufficient however, remains to give our readers a good idea of this new form of treatment.

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The *Medical Fortnightly* draws attention to the somewhat singular fact that of the presidents of the American, Medical Association elected since 1880—twenty-two in number—eighteen have been chosen from the ranks of surgeons or surgical specialties. Internal medicine has had two

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representatives, and the general practitioner has been honored twice. This is a unique fact, and one which emphasizes the conditions of medicine in the United States, and is in striking contrast to its sister association—the British Medical. While finding no fault with the personnel of those selected to fill the chair of the American Association, it urges the claims of medicine for a division of the honor. It also adds that no one could more fittingly bear the honor than our old friend, Dr. William Osler (a Canadian), of Johns Hopkins' University, "the leader of internal medicine on this continent, if not the English world." It asks for his election to the presidency in 1901.

## PERSONAL.

The Hon. Dr. Borden, Minister of Militia, will, it is said, sail shortly for England. The trip will be to seek rest, while, at the same time, he will transact some business with the War Office.

Dr. Fiset, one of the surgeons of the 2nd Battalion Royal Canadian Regiment serving in South Africa, was, a short time ago, taken prisoner by the Boers. He was recently released, and has rejoined his regiment. His return was warmly greeted, for he is a universal favorite with both officers and men.

The death in action, near Pretoria, of Lieut. Harold Borden, of the Canadian Mounted Rifles, only son of the Hon. Dr. Borden, Minister of Militia, is deeply regretted by all who knew him. A Third Year medical student at McGill University, he gave promise of a brilliant future. The blow is a severe one to his father, as he was an only son, and his death breaks a record of several generations of medical men. He died with his face to the foe—for Queen and Empire—the Commander-in-chief, Lord Roberts, having had his gallantry brought more than once to his notice. Personally known to him, the writer grieves at his death and the loss of a dear young friend.

Surgeon Capt. Sanford Fleming, Princess Louise Guards, has been appointed A.D.C. to Major-General O'Grady—Haly, the new Commandant of the Canadian Militia.

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Dr. Craik, Dean of McGill Faculty of Medicine, was recently entertained to an informal supper at St. James' Club. During the evening he was presented with a beautifully illuminated address accompanied by his portrait in oil.

Lieut.-Col. Neilson, Director-General Militia Medical Staff, has gone for two weeks' fishing to the lakes north of Quebec.

The death early in July of Dr. Fafard, Professor of Chemistry in Laval University, Montreal, was an unexpected event. He was a strong member of the Laval Faculty of Medicine, and was greatly esteemed by those members of the English medical profession who had the pleasure of his acquaintance.

The degree of Doctor of Law has been conferred by the University of Michigan and Dickinson College upon Dr. Lewis Stephen Pilcher, of the Methodist Episcopal Hospital of Brooklyn, and editor of the *Annals of Surgery*.

# Book Reviews.

**Cancer of the Uterus.** Its pathology and symptomatology diagnosis and treatment; also the pathology of diseases of the endometrium. By Thomas Stephen Cullen, M. B., Toronto; Associate Professor of Gynecology in the Johns Hopkins University. With eleven lithographic plates and over three hundred black and white illustrations on the text, by Max Brödel and Herman Becher. New York, D. Appleton & Company, 1900.

We cannot refrain from expressing our feelings of pride and gratification, which will, we believe, be shared by all Canadian physicians, when we look at this monumental monagraph of seven hundred pages, all on the subject of cancer of the uterus, and reflect that the most exhaustive work that has ever been written on this subject has been written by a Canadian. The scope of the work may best be judged from a portion of the preface, which we quote: "The number of cases of cancer of the genital tract coming too late for operation is so appalling that the surgeon is ever seeking to devise ways and means by which the dread malady may be more generally detected at the earliest possible moment—at a time when the complete removal of the malignant tissue is still possible. But since it is the general practitioner who as a rule in first consulted, upon him largely falls the responsibility of arriving at a timely diagnosis." In this volume it has been the author's aim to give the family physician a clear idea of the early signs of carcinoma, in order that he may always be on his guard and may not treat too lightly any suspicious indications which may be present. A perusal of the text reveals the high character of the

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work. While we would wish most earnestly that the book might be widely read by all general practitioners, we fear that only a few of the most advanced ones will do so. Many of the chapters are devoted to the microscopical diagnosis, and will be eagerly studied by the specialists who are anxious to make an accurate diagnosis at the earliest possible moment after seeing the case. The work is therefore invaluable to the specialist, who cannot afford to be without it. The question as to what operation should be performed in a given case and the dangers and difficulties of each are thoroughly discussed. There are complete separate chapters on cancer of the cervix and cancer of the body of the uterus. The chapters on differential diagnosis are simply perfect. There is a special chapter on pregnancy complicated by cancer of the cervix, for which the author recommends hysterectomy by the abdomen. There are two excellent chapters on the etiology of the disease, the author leaning to the view that heredity seems to have very little influence; he says the weight of evidence is against the parasitic theory. But the best chapter of all is the appendix by Knowsley Thornton, of London, which should be read by every general practitioner, and from which we give a few extracts: "How is an early diagnosis to be made? Clearly by neglecting no menstrual departure from the normal, however trivial it might at first sight appear, but at once to encourage the patient to accurately describe symptoms, and, above all, to insist in the most determined manner on a local examination. Here it will be apparent that I, as a consultant, appeal for help to the great body of those who are now listening to my remarks, to my professional brethren engaged in general practice. I, in common with those situated as I am, too seldom have an opportunity of diagnosing early, because the majority of the patients come to us too late, when the disease has advanced nearly, or quite, beyond the limits of surgical aid. Let me, then, appeal to all engaged in family practice who listen to me here, and to that larger body who may read my words when reproduced in the medical journals, to sternly cast aside that too great modesty, or that tendency to treat as trivial, small symptoms, and to at once take alarm about, and carefully investigate every case in which there is brought to their notice an abnormality in menstruation or a vaginal discharge of any kind, however trifling. A very grave responsibility lies at the door of the medical profession for the small progress made in the early diagnosis of uterine cancer and its successful treatment. How constantly is the consultant told, 'I mentioned it to my doctor weeks or months ago, but he said, "Oh, it is nothing. I will send you a little medicine or a little injection," and never even suggested any internal examination, so I did not like to trouble him again till the pain became so bad or the discharge so troublesome, and then he examined me and said I must have special advice at once.'" Space prevents us from making other extracts, but the work is full of valuable advice, and should be in great demand. A. L. S.

**Thompson's Practical Medicine.—A Text-Book of Practical Medicine.** By William Gilman Thompsonl M.D., Professor of Medicine in Cornell University Medica, College, New York City, Physician to the Presbyterian and

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Bellevue Hospitals, New York. In one magnificent octavo volume of 1010 pages, with 79 engravings. Cloth, $5 net; leather, $6 net; half morocco, $6.50 net. Lea Brothers & Co., publishers.

Works on the Practice of Medicine have been of late years produced with great profusion, until one is almost at a loss to make a selection. This volume by Professor Thompson, of the Cornell University Faculty of Medicine, New York City, is so thorough and complete, that no one can make a mistake in putting it in a handy place in his library. Profesosr Thompson is a well-known worker, and the advent of a new century makes appropriate a comprehensive review of the present status of medical practice. It is the aim of this book to offer such a presentation. Special effort has been made to set forth clearly and simply those facts and principles which have received clinical proof, and to avoid those theories which have merely a speculative basis. The recent progress in pathology, clinical microscopy and bacteriology have greatly advanced the realm of definite knowledge, and corresponding modifications have taken place in previously existing views of the etiology, prevention and treatment of disease. The work is eminently practical, for the author has given his personal experience, which has extended over twenty years, and he writes with faith. He assumes that curative medicine is the avowed object for which medical men practice their art. He has therefore given especial care to the therapeutical sections, which are detailed and complete. A number of photo-gravures are introduced mostly from the author's collection, and very much enhance the value of the work. As a text-book for students, it must take a foremost place, and we confidently look for it being placed among the books recommended at all our Medical Schools. It is placed at a price within the reach of all, which indicates the confidence of its publishers in an unexampled sale. The type is particularly good, and reading does not tire the eyes.

F. W. C.

**The Treatment of Fractures.** By Charles Locke Scudder, M.D., Surgeon to the Massachusetts General Hospital, Out Patient Department; Assistant in Clinical and Operative Surgery in the Harvard Medical School; assisted by Frederic J. Cotton, M.D. With 585 illustrations. Philadelphia: W. B. Saunders, 925 Walnut Street, 1900. Canadian agents, J. A. Carveth & Co., Toronto, Ont. Price $4.50.

The volume here given us by Scudder, on a subject of such interest to not only the surgeon, but the general practitioner, is really one of unusual merit and well worthy of unlimited praise. It is especially interesting as fractures are of such frequent occurrence at all ages, and are liable to be followed by deformity or some permanent impairment of function, ending perhaps in litigation, that any work of such a practical nature as the one under review, whereby the diagnosis of these kinds of injuries may be simplified, must receive a warm and abiding welcome. The general use of anesthesia in the examination and the initial treatment of fractures,

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especially of those near or involving joints, has made diagnosis more accurate and treatment more intelligent. The application of the Rontgen ray to the diagnosis of fracture of bone has already contributed much toward an accurate interpretation of the physical signs of fracture. The author says that this greater certainty in diagnosis has suggested more direct and simpler methods of treatment. Antisepsis has opened to operative surgery a very useful and profitable field in the treatment of fractures. The final results after the open incision of closed fractures emphasize the fact that anesthesia, antisepsis, and the Rontgen ray are making the knowledge of fractures more exact, and their treatment less complicated.

This work is intended to serve as a guide to the practitioner and student. Many of the details in treatment of fractures are described, and as far as possible these details are illustrated. Mechanical simplicity is advocated. An exact knowledge of anatomy combined with accurate observation is recognized as the proper basis for the diagnosis and treatment of fractures. The expressions "closed" and "open" fracture are used in place of "simple" and "compound" fracture. "Closed" and "open" express definite conditions, referring to the freedom from, or liability to bacterial infection. The old expressions are misleading despite their long usage.

This work clearly explains the latest and best methods whereby we may correctly diagnose fractures, and then in an easy manner shows us the proper treatment to be used. One chapter deals with the uses of plaster-of-Paris and another takes up the ambulatory treatment of fractures. The volume is essentially practical, and should be in the possession of every practitioner who is desirous of obtaining a good practical grasp of the subject of the diagnosis and treatment of fractures. The work is more than well supplied with illustrations which are of unusual merit. We have no hesitation, after a close perusal, in recommending the book, which will prove of particular use to the general practitioner.

R. C.

**A Text-Book of Practical Therapeutics.** By Hobart A. Hare, M.D., B.Sc. Eighth edition, revised and largely re-written. Lea Bros. & Co., Philadelphia and New York, April, 1900.

This eighth edition in less than ten years proves the truth of the aphorism that "nothing succeeds like success." The secret of Prof. Hare's success in the volume before me lies in the fact that he knows the busy practitioner needs but a hint to place him on the right track, while the overburdened student cries aloud to be delivered from lengthy and erudite discussions of minute physiological actions, and appreciates something he can easily remember and make good use of in his prospective practice. In the nearly eight hundred pages of reading matter, there is not a redundancy of expression nor a word too much. Neither is there the jerky dogmatism that marks the quiz compend. The work is invaluable to the world of readers to whom it appeals, and will, I hope, see many revisions and editions at the hands of its capable author.

To those who, like the author, are teaching the subject, there will be, of course, always minor differences. Among them, the perennial question of classification. Personally I incline to Schmiedeberg, —while admitting that Hare's is handiest in a rush.

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The illustrations are good and the colored plates excellent; the letter press is above reproach, and the paper, luckily, unglazed. Next to Bruton's Lectures, it is a book that should be on every practitioner's desk. R. W.

**Atlas and Epitome of Special Pathologic History.** By Docent Dr. Hermann Dürck, Assistant in the Pathologic Institute, Prosector to the Municipal Hospital, Munich. Authorized Translation from the German. Edited by Ludwig Hektoen, M.D., Professor of Pathology in Rush Medical College, Chicago. Circulatory Organs, Respiratory Organs, Gastro-Intestinal Tract. With 62 colored plates. W.B. Saunders, 925 Walnut Street, Philadelphia. 1900. Canadian Agents, J. A. Carveth & Co., Toronto, Ont. Price, $3.00 net.

We take pleasure in calling attention to this excellent translation of Dr. Dürck's Atlas and Epitome. Bearing in mind how difficult it is to correctly represent pathological appearances in colored plates, we have no hesitation in stating that the illustrations are, with few exceptions, faithful and typical pictures of the various pathological processes described. They are not the idealised and almost schematic representations of tissue changes such as adorn certain text-books of pathological histology. The plates on arteriosclerosis and arteritis, on adipositas cordis, on the pneumonias, are worthy of special notice. The work is well up to the standard of excellence of the Saunders' Hand Atlases, and is calculated to stimulate the student of pathology to personal observations of morbid histology. A. B.

**A Manual of Obstetrics.** By A. F. A. King, A. M., M. D., Prof. of Obstetrics and Diseases of Women and Children in the Medical Department of the Columbian University, Washington, D. C., and in the University of Vermont: President (1885-86-87) of the Washington Obstetrical and Gynæcological Society; President (1883) of the Medical Society of D. C.; Fellow of the British Gynæcological and of the American Gynæcological Societies; Consulting Physician to the Children's Hospital, Washington, D. C.; Obstetrician to the Columbian University Hospital; Member of the Washington Academy of Science; of the American Association for the Advancement of Science; Associate-Member of the Philosophical Society of Great Britain; and Member of the Medical Philosophical, Anthropological and Biological Societies of Washington, D.C., etc. Eighth Edition, revised and enlarged. 264 illustrations. Lea Brothers & Co., Philadelphia and New York, 1900.

The value of King's Manual of Obstetrics is perhaps best emphasized by the fact that since the first edition appeared in 1882, there have been no less than eight editions printed. It must have filled a want amongst students, or it most certainly would not have become so popular. Students have not the time to read systematic treatises, but need the facts stated as briefly and comprehensively as possible. The manner in which Dr. King italicizes the words that are important to convey the exact ideas he is trying to impress is certainly to be commended. It is up-to-date in theory, and

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is correct, we think, when remedies are to be used, in not simply mentioning them by name, as so many works do, and which is proper for larger works, but the actual combination in the form of prescription. This, we believe, is much better for students. Whether for student or busy practitioner, we can most heartily recommend the work, whether for the initial study of the work or for refreshing the memory. For its small cost it should be found on every student's and practitioner's table. H. L. R.

**A Practical Treatise on Sexual Disorders of the Male and Female.** By Robt. W. Taylor, M. D. Lea Brothers & Co., New York and Philadelphia, 1900.

This work is eminently a practical one, and not a compilation as so many are at present. It is evidently written largely from the author's own experience and not overburdened, and is just what the general practitioner requires. J. P.

## PUBLISHERS DEPARTMENT.

KEEP TAB ON TIME.—Believing thoroughly that "a thing of beauty is a joy for ever," and that an article of beauty and utility combined is worthy of preservation, The New York Pharmacal Association has prepared for distribution to the medical profession a handsome and artistic *perpetual* calendar, which is now ready for mailing. Instead of presenting a calendar at the beginning of the year, according to the usual custom, the above company prefers the season when the physician is not deluged with all sorts and conditions of chronological recorders, and is thus better enabled to welcome and appreciate such an addition to his office. The new Lactopeptine Perpetual Calendar is not intended for hanging upon the wall, but to stand upon the doctor's desk, and for this reason has a strong easel back to support it. The coloring is exceedingly soft and attractive, consisting of delicate shades of lavender, purple, crushed strawberry and buff yellow. The few words relative to Lactopeptine are entirely unobtrusive, and do not interfere in the least with the general artistic effect. In the near foreground on either side are two gracefully draped female figures with flowing hair; around the edges appear the various signs of the Zodiac.

One of these calendars will be sent to any physician who may request same.

SANMETTO IN PROSTATITIS AND CYSTITIS.—Dr. F. R. Dobson, of New Orleans, La., late Surgeon U.S.A., writing, says: "While Surgeon in First Division Hospital, stationed at Jacksonville, Fla, I had occasion to see an interesting case of prostatitis treated with Sanmetto, with entire success. The patient was a private in the Second Nebraska Vol., and his condition upon entering the hospital was deplorable, the bladder being distended with urine, the overflow dribbling constantly. His condition was traceable to gonorrheal infection. Since my return to New Orleans I treated with Sanmetto a case of purulent cystitis, which had resisted all other treatment. The result of the taking of one bottle of Sanmetto was permanent relief."

### AN ADDITIONAL HONOR.

We have just been advised of the award by the Judges of the Paris Exposition to Messrs. Wm. R. Warner & Co., of Philadelphia, New York and Chicago, of the highest medal prize, for their justly celebrated pharmaceutical products. This makes the 17th World's Fair highest prize, which has been awarded this well-known and justly celebrated firm, and we join in congratulations to Messrs. Wm. R. Warner & Co. over their well-merited and unbroken line of victories in competition with the world's manufacturers.

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CANADA
MEDICAL RECORD

SEPTEMBER, 1900

# Original Communications.

## AN ADDRESS ON TUBERCULOUS LESIONS FROM A CLINICAL POINT OF VIEW.

*Being the Address in Surgery delivered before the Canadian Medical Association at Ottawa, Sept. 13th, 1900.*

By EDMUND OWEN, M.B., F.R.C.S.

Surgeon to St. Mary's Hospital, and Consulting Surgeon to the Hospital for Sick Children, Great Ormond Street, London.

MR. PRESIDENT AND GENTLEMEN,—Though the substance of the Address which I have the high honor of presenting to you may entirely fail to arouse in you any measure of satisfaction, yet I think I may, at any rate, claim your kind appreciation for its title, for it gives you the assurance that I am not going to ask you, even in your imagination, to pass any of this September day in that gloomy room in which Death is made to deliver up his grosser secrets; nor in that other place where, in an atmosphere of methylated spirits and oil of cloves, you are accustomed patiently to unravel the tangled threads of morbid tissues. My remarks will deal with tuberculous lesions as the surgeon meets them day by day in hospital-ward and operating-theatre, and in private practice. And if I shall find occasion to ask you to go beyond these spheres, it will be to take you to some of those beautifully placed convalescent institutions in which, when full of gratitude for having triumphed over the distress of chronic disease, or the risks which are inseparable from its operative treatment, the tuberculous patient spends possibly the very happiest weeks of his life.

It is, I make bold to say, a good and wholesome thing for a surgeon now and then to get away from the pathologists

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and morbid histologists—to play truant, as it were, from his unbending schoolmasters. In recent years there has been a little too much inclination to apotheosise the morbid anatomist. His brow has been decked even with roses, and now standing high in his suit of sable, he looks upon the clinical surgeon as if his chief duty were to supply him with material.

In the title of my Address are the words "from a clinical point of view," and desiring to emphasise the fact that the word *clinical* related solely to remarks made and work done in the sick-room and in the theatre, I thought it well to call attention to its exact meaning. But on looking it out in "Liddell and Scott," I found to my dismay that κλινη was not only *that on which one lies, a couch or bed*, but, secondarily, a *bier*. The discovery somewhat disconcerted me. If a *bier*, why not a *mortuary-table?* At any rate the word *clinical* is of wider significance than I supposed; so that the pathologist might have right on his side when he claimed that clinical instruction, begun at the bed side, and carried, perhaps, into the operating-theatre, is not complete until he has written the epitaph.

Even on this side of the middle of the dying century, institutions were in existence in which much pathological work was actually done within the walls of the hospital itself. This, of course, we know to have been wrong. But surely we have now gone to the other extreme; the pathological laboratory is constantly getting further and further away from its source of supply. The pathologist is no longer a practitioner of medicine, his interest is not in the *case* but in the *subject*. Like the carpenter, he does not interest himself in *living* material; his thought is only for dead tissue. The surgeon sees the human tree during its life (and perhaps helps to fell it), but he now, unfortunately, rarely follows it off his estate. So with the student; he does his clinical surgical work at one time and in one place, and his pathological work at another, and he is unable, I regret to say, to follow any individual case, or any part of it, straight from the ward to the laboratory.

The present arrangement is, of course, incapable of

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alteration, but it is an unfortunate one for the student; and on his account it behooves the surgeon to do all that he can towards wielding the pathological details of his cases with the clinical features, so as to represent to his class that the two aspects are inseparable, and must always be considered together. If, for instance, he is demonstrating a tuberculous knee-joint, he should, whilst discussing the clinical features of the case, explain precisely the histological changes that are taking place; and supposing that a resection or amputation is eventually resorted to, he should show on the fresh specimen in what respect the morbid conditions harmonise with or differ from the account which he had described. He should, as far as possible, make his teaching independent of his colleague in the laboratory, for the specimen which the latter takes out of a jar of formalin or alcohol is no more like the condition as it exists in the wards than canned salmon is like a fresh-run fish.

The clinical surgeon has sometimes been a little too much under the influence of the experimental pathologist and bacteriologist. When an important surgical problem awaits a solution which cannot be effected in the ward or on the operating table, the clinical surgeon turns to his enthusiastic and obliging friends in the laboratories, who, in order to help him, straightway proceed with careful thought and gentle hands to sacrifice upon the altar of Hygeia some mongrel curs or a few of those tail-less rodents, which, so far as I can see, have been provided solely for the use of the experimentist; then, because such and such a thing happens in such and such circumstances in the laboratory to the dog or the guinea-pig, the pathologist is apt to assume that in different circumstances it must happen also in man himself!

When in due course the pathological and bacteriological Athanasius formulates his Creed, I am afraid that I shall be burned at the stake. But in saying this I trust that no one will jump to the conclusion that I would hinder experimental research. Indeed, I think it absolutely necessary, and I am strongly of opinion that the life of a man is of more value than that of many sparrows (or guinea-pigs), and that the clinical surgeon is deeply indebted to the experimentalist for much valuable collaboration. But if there is one matter more

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than another in which the work of the experimentalist has led to faulty generalisation from a clinical point of view, it is with regard to the course of certain tuberculous lesions. Nor will anyone think, I trust, that I would underrate the value of the work of the experimental pathologist; it certainly is not so, for it is to these workers that we owe our knowledge of the precise cause of diphtheria as well as of tuberculosis—of tetanus and erysipelas, and of many other serious diseases. And knowing the cause we have been enabled in many cases greatly to influence the course of the disease by treatment. Indeed, it would be almost impossible to over-estimate the practical value of experimental laboratory work both to the profession and to the public. Nevertheless there are some of the public who, in their ignorant well-meaning, would once and for all stop such beneficent research. But stranger still, there are some members of our own profession in England who also try to get in the way of scientific progress. Fortunately, however, they have not the power of doing much harm!

Not long ago we used the word "strumous" or "scrofulous" when we were in a surgical corner; but to-day these indefinite terms are deleted from our nosology; indeed, they are devoid of scientific meaning, and we now call *tubercle* by its proper name, our patients reaping the benefit of our greater precision.

From the medical point of view an unusual amount of attention has lately been drawn to the subject of tuberculosis by means of excellent societies which have recently been organized to carry on a never-to-be-ended warfare against the disease. Taking its birth upon the Continent, the scheme has received a considerable amount of support in Canada, in the United States, in England and elsewhere, and its effect cannot be but for good.

## Three Important Facts.

There are three great facts in connection with tuberculosis of which the public must be made fully conscious:

The first is that the disease is *communicable*. The truth of this fact we have ourselves only of late entirely realized.

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The public, therefore, must be allowed a little time before they generally accept it. But accepted it must be, and it behooves each one of us to do all that we can towards promoting its acceptance.

The second is that the disease is *preventable*. This follows almost as a corollary to the previous statement, and when the truth of it becomes fully understood how great will be the responsility of those who wilfully disregard it.

The third fact is that the disease is *curable*. And as we are to-day considering certain surgical lesions of tuberculosis from a clinical point of view, I shall seize this opportunity of entering somewhat fully upon the question of curability.

## THE CURABILITY OF TUBERCULOUS LESIONS.

A few years ago tuberculosis was regarded as a well-nigh incurable affection, for the word had been chiefly reserved for hopeless cases of pulmonary consumption, and of meningitis complicating certain chronic diseases. To call a surgical lesion, therefore, *tuberculous* was tantamount to signing the patient's death-warrant. It was in the public estimation a term of dreadful omen. But among the many uncertainties of our professional environment, one thing has of late become quite certain, namely, that tuberculosis is not necessarily of the intractable nature that it was formerly considered to be. So far as my practical acquaintance with the disease is concerned—and I have worked at a large general hospital, and at the largest children's hospital in London for a quarter of a century—tuberculous lesions are exactly what they used to be. But we know much more about them, and careful clinical study and microscopical and experimental work have enabled us to treat them more successfully, and, therefore, to warrant us in taking a much more hopeful view of them. But I would like to know if the surgical lesions of tuberculosis which are met with in your dry, bracing climate are just as we have them in Western Europe. Many of you have studied tuberculous lesions under your own bright skies and also in the mother country, whose borders are washed by the seas and whose life is so greatly influenced by the Gulf-stream.

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From your cradle you have been taught that the sun never sets on the Empire of our dear Sovereign Lady, but I am afraid that when some of you have come over to us in a bad season you have wondered if there are not parts on which it never rises. Well, do you find that tuberculous lesions are exactly the same clinically in the two hemispheres? Every country has a climate, just as it is said to have a form of government, which is equal to its deserts; ours is a damp climate which exactly suits the soil and the race; but it is a bad one for the unhappy individual in whose blood the bacilli of tuberculosis are lurking, as well as for those who by heredity or surroundings have acquired that condition of tissue which renders it vulnerable by the mean bacilli of tuberculosis, and adapts it for their cultivation.

Sometimes when I have been going round my wards I have asked a visitor to note how large a proportion of the cases are tuberculous. Is it thus also in *your* surgical work? Do chronic tuberculous affections of the hip-joint, knee, spine, lymphatic glands, shoulder, elbow, foot and hand, represent a very large proportion of lesions which come under treatment by the general surgeon? Have you, in proportion, just about as much tuberculous disease in Canada as we have at home; and does it take the same course?

Much of my clinical work has lain amongst senior students; I come in contact with them just as they have left the laboratories and are proceeding to put what they imagine to be the "finishing touches" upon their professional education. They have spent many delightful hours in a pathological laboratory and in a white cotton smock; they have cultivated and even tamed bacilli; they have seen how potent they may be for evil, and they are firmly of opinion that if once such germs gain access to a suitable spot in a suitable individual, nothing short of the most vigorous surgical measures can suffice for the eradication of the disease and for the emancipation of the host. This is the students' bacteriological faith, and except they act up to it their patients cannot be saved. Many young practitioners also hold that faith. Where do they learn it? Not in clinical surgery. The public also have begun to believe it; but the public will be-

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lieve anything that they are told if only they are told it often enough. And if the statement is couched in semi-scientific or mysterious phraseology they seize upon it with all the greater avidity. Otherwise, how would bonesetters, vendors of patent medicines, and other quacks, qualified and unqualified, flourish like a green bay tree in a sunny corner of an arboretum?

But is the outlook in advanced tuberculous disease necessarily so hopeless in the absence of active surgical treatment? To answer this important question I will instance an imaginery case of a young man who, a year or so previously, hurt his back in a fall at a gymnasium. He has now pectoral neuralgias, and dull pains between his shoulder-blades and in his back, which have probably been ascribed to "rheumatism." Eventually the discovery is made that the third and fourth dorsal spinous processes are unduly prominent, and it is evident that the bodies of those vertebræ have undergone tuberculous disintegration. The disease is close behind the arch of the aorta, and the surgeon is unable to get at it. He cannot scrape it, and he cannot even irrigate it with germicidal lotions. I believe that there are some surgeons who would attack it if they could: *rien n'est sacré pour un sapeur*; but fortunately one cannot possibly get at it. What, then, is to be the future of this patient? Is he going to die the death, as the guinea-pig would, in the laboratory? Most certainly not. Everyone here has acquaintance with such an individual, or if he does not know him personally he has seen him in the street. He is rather a short man with peculiarly high, square shoulders, and with a boss between them. And not only has he long since outgrown his tuberculous disease without any operative assistance whatever, but could we see him in his own home, we might not improbably find him —and I say it with some regret—surrounded by a number of apparently healthy sons and daughters.

Such a case is one of great clinical importance; it shows that a man with an undoubted tuberculous lesion of the first magnitude can completely recover without having undergone any operative procedure. At the end of the 19th century it is somewhat unusual for any patient with any surgical affec-

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tion to be allowed the opportunity of showing what he can do without submitting himself to operation, so that such an account as that which I have just instanced is not only important but actually interesting. One rarely hears speak now of the *vis medicatrix Naturæ:* surgical zeal has apparently rendered it not only obsolete but superfluous.

Another instance of the favorable course which severe tuberculous disease may run in the absence of active surgical interference, is seen in the case of old-standing hip-joint disease, the boy actually "growing out of his trouble." The disease, let us suppose, began at that period of life when it is customary to send a boy to school, and his school-life was frequently interrupted and was continuously clouded by the affection. But he is now a young man at College, and though he walks lame and is precluded from taking an active part in athletics, still he is vigorous, and he has evidently and completely triumphed over his disease. I am not sure that I have in clinical work ever before used the specious expression, "growing out of a disease;" and possibly I might not do so now if I thought that there were any students or unqualified persons present, for its adoption might prove unfortunate or even dangerous. It is a rather favourite expression, however, amongst parents and other ill-informed persons when confronted with a child with a tuberculous lesion. Would they expect a garden to grow out of its weeds or a field out of its thistles? No; it is a popular superstition, but, like most erroneous beliefs, it is founded on a substratum of truth. For, as a matter of fact, many patients do "grow out of" tuberculous disease, and, strange to say, sometimes most markedly so after a surgeon has made the clear pronouncement that without operation recovery is quite impossible. A boy, for instance, has chronic tuberculous and suppurative disease of his tarsus; he is albuminuric and very ill. His able young surgeon says that unless the foot is removed the boy will die. This is an unwise thing for any surgeon to say, for he cannot possibly know for certain what is going to happen. But what *may* happen is this: The operation is declined, the child is put under the care of another practitioner who, though not so clever a surgeon, is, perhaps, older and a

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better man of the world. By good luck rather than by good management the disease clears up, and in a couple of years' time the boy is walking about with scarcely a limp. "See that boy?" says the proud father, "well, Dr. Omniscient wanted to cut off his foot, but his mother and I would not let him!" According to the rules of the game the foot, of course, ought to have been amputated; but Nature does not always play according to the rules, as the young practitioner sometimes finds out to his cost. *Knowledge* is the prerogative of youth, but *wisdom* should come with years.

I recollect that I have wandered from that case of chronic hip-joint disease; I was instancing it merely to say that, though the head of the thigh bone and the socket in which it worked have been quietly destroyed by the growth of tuberculous granulation tissue, so that the limb is greatly shortened, still, it is now, years afterwards, solidly fixed and fairly serviceable. The skin has remained unbroken, and the man has completely triumphed over his disease.

In connection with this little batch of reports, I would like to make a few disconnected statements, chiefly from a clinical point of view:

1. Chronic inflammation of a joint in a child or young person is always tuberculous—except in those very rare cases in which it is due to hereditary syphilis or osteo-arthritis.

2. Tuberculous inflammation may completely destroy a joint, and then leave it solidly and soundly synostosed, without the surrounding tissues or the skin having been implicated.

3. If tuberculous granulation-tissue breaks down into a fluid, that fluid is not *pus*, and the collection is not, properly speaking, an *abscess*—unless, by bad fortune, or by worse surgery, it has become infected by septic micro-organisms.

4. The fluid collection is not to be treated as an abscess—by incision and drainage, that is—but is to be opened and emptied, and scraped and cleansed of its unhealthy lining of granulation-tissue. Then the wound in the skin is to be completely closed by sutures; firm pressure is to be evenly applied and the part is to be kept absolutely at rest. It is no news to most of you to be told that the success attending this line

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of treatment leaves, as a rule, little to be desired, or that for this important advance in practical surgery we are chiefly indebted to the patient researches of our friends with the smock-frocks and the guinea-pigs.

5. I have failed to discover that iodoform is of any peculiar value in the treatment of tuberculous lesions. At any rate I have long since discarded it, and I have not noticed any falling off in the results of my practice in consequence. Iodoform is an irritant and a poison; it is apt to be septic, as germs can grow upon it, but I have no knowledge of the truth of the statement that mushrooms have actually been cultivated on it.

Sometime since a lady was sent to me for my opinion about a tuberculous ulcer of the anus which a practitioner had long been treating with iodoform. She earnestly begged me to consider if I could not recommend some other local application, as she said that the smell of the yellow powder rendered her "socially objectionable." This was for her a very serious matter, as she kept a fashionable boarding-house, and whilst many members of her household seemed to notice the peculiar odour, some few of her young men "paying guests" actually appear to recognize the drug itself.

I confess that I have a sort of feeling of sorrow for a surgeon who thinks that he cannot successfully carry on his practice without iodoform, just as I have for the lady who deems patchouli to be indispensable for her toilet.

## The Forcible Straightening of Carious Spines.

The direct treatment of the angular deformity resulting from tuberculous disease of the spine is a subject that a few years ago was thrust somewhat vigorously upon us, not only by articles in the medical papers, but by the reproduction of photographic representations of ghastly clinical procedures in the pictured journals of the lay press. This is scarcely the way in which one would expect solid surgical work to be advanced. One remembers that there was a somewhat similar outburst in the lay press a few years ago, when the Koch treatment of tuberculosis was being boomed in Berlin. For this, however, the illustrious Koch must not be held respon-

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sible; he was hurried into bringing forward his work ere he had assured himself that the results of his injections justified their being regarded as *curative*. Immediately there was a rush to the German capital, and medical men lent themselves and their names to lay journalism and their portraits to the illustrated papers, passing glad to obtain notoriety in such a beneficient, or at any rate in such a popular, movement.

I do not know how it may be with you, but in Western Europe every new method or invention is at once greedily accepted and not improbably made the means of unmistakable advertisement. It does not much matter whether it is to turn out a real success or not, the point seems to be to have one's name associated with it whilst it is on the crest of the wave.

I say that I do not know how it may be with you, but I hope and I think that in your peaceful Arcadia you can practice your profession undisturbed by many of the anxieties, struggles and temptations by which your less fortunate *confrères* are sometimes well-nigh overwhelmed in an older country. And long may it continue with you, not only for the good of your honorable profession, but also for your own self-respect and happiness.

To affirm that the forcible straightening of carious spines must needs be unsurgical simply because it is a reversion to the ways of the bone setter would be unfair, for the blundering bonesetter sometimes did good by chance. But at any rate he experienced none of that sense of responsibility which a surgeon must feel when he is proposing to straighten a tuberculous spine. It is obvious that in straightening the angle the tuberculous ulcer of the vertebræ must be widely opened out, and that, if the neural arches have been already cemented together, this rigid support must be broken across. And, supposing that this is done, and that the patient survives the risks which are inseparable from the procedure, will the widened osteal ulcer duly heal and the neural arches again become solid? Possibly so. But—and this is the point—will there be no further recurrence of the hump?

Though I should be grieved to stand in the way of surgical advancement, I do not mind getting in the road and

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temporarily impeding traffic whilst we are taking time to consider the route, and are assuring ourselves that the stream of surgical practice is going in the right direction. My opinion is that the deformity of Pott's disease does not lend itself to operative treatment; that forcibly to interfere with it is to thwart Nature in her good attempts at effecting a curative consolidation in her own way—and Nature's ways as a rule, are not unworthy of our respectful recognition. I think, further, that in a short time we shall hear very little about this method. This is what I *think*, but I am absolutely *sure* of this, that if a child of my own had an angular deformity of its spine, no person on earth should be allowed roughly to meddle with it. This is the only trustworthy way of testing one's opinion concerning the therapeutic value of speculative methods of treatment, and when a surgeon is planning some new scheme of procedure, it is a good thing for him to measure it out first with the golden rule—would he accept such and such a line of treatment for himself, or for those nearest and dearest to him? But surely, after all, each one of us actually does this, though some apparently have greater belief in heroic measures than others. At any rate, let us not be precipitate or over-enthusiastic with respect to each untried method as it is introduced; *festina lente.*

There is a small class of cases for which forcible rectification of the angular deformity may, perhaps, eventually be found suitable, namely, in a certain few of those in which pressure by bone, or by organizing inflammatory deposits, has taken place upon the anterior surface of the cord, so that the patient has lost the power of voluntary movements in the lower extremities. In a few such cases I might perhaps be eventually inclined to resort to forcible straightening rather than to a laminectomy, an operation of which, by the by, I have but a poor opinion.

The humped back of spinal disease is of course an opprobrium, and it is small wonder that the surgeon is anxious to efface it. But if he had given proofs of such laudable anxiety at the beginning of his treatment of the case, he would probably have had no hump to deal with. I have no hesitation in saying that, even at the present time, the treat-

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ment of spinal disease in its early stages is too often half-hearted and sometimes actually blameworthy. It may be urged by way of excuse that at the very beginning of spinal disease the symptoms are so equivocal that the practitioner hesitates even to whisper his opinion, lest the disappearance of the symptoms should suggest that after all he is an alarmist. He knew that the girl had symmetrical pains in her chest, belly and legs; he knew that she got easily tired at play, or that she was inclined to loll and lie about when others were full of activity, and that, regardless of nursery manners, she persistently sat at meals with her elbows on the table. He suspected spinal disease; he even told the parents that the girl should be kept quiet. He may actually have gone so far as to sketch out a plan of treatment which was designed to secure a certain amount of rest, but he was slack in seeing that even this small measure was carried out, in short, he had not the courage of his opinions and the case was allowed to drift.

Oh, for the spirit of Lady Macbeth, who called out to her weak-kneed spouse and fellow-practitioner,

Infirm of purpose! Give me the dagger!

I am a great admirer of Lady Macbeth, though I am fully aware that her character is not faultless. She was not the sort of person, perhaps, to be trusted with the dissection of tuberculous glands from the neck, or of operating on a case of torticollis, but how splendid she would have been in the treatment of early spinal disease! There would have been no half-measures with her!

## The Treatment of Vertebral Caries.

If a practical surgeon were asked what is the proper treatment of early spinal disease, he would unhesitatingly say *Rest!* Yes, absolute and uninterrupted rest. But there is only one way of ensuring such rest for a child, and that is by making him lie flat in bed. As I shall set forth directly, he is not to be kept actually *in bed* all the time; but in every case the treatment is at any rate to be commenced by imprisoning him in a pillowless bed. This, I feel sure, is the only way of successfully inaugurating the treatment of *rest*.

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But it is of little use if, when in bed, the patient is allowed to roll about, to sit up for his meals, or to hang over the side of the bed in order to pick up a dropped toy. The details of the treatment must be seriously considered, and the medical man must make it his business to see that they are loyally and thoroughly carried out. He must not content himself merely with giving his instructions; the parents will very likely want careful looking after, as well as the boy, or else as soon as the doctor has left the house, or at any rate after a short period of rest, the boy will probably be allowed to do pretty well what he likes, and so the case will quietly drift. What the circumstances demand is the presence of a sort of clinical policeman in the house, in the shape of a hospital nurse.

I know that there are all sorts of schemes, corsets, apparatus and braces (as my American friends call them) for treating spinal caries without keeping the patient flat. But they are all wrong; wrong in theory and wrong in practice; and if they could be cast into the bottomless pit, and every case of spinal disease could from the beginning be treated by continuous rest in the horizontal position, there should be no more of those unsightly humps to invite speculative interference. Of course, I do not include in my anathema Phelps's box-splint, the double Thomas's splint with head piece, or any form of cuirass which takes the child in bodily and keeps him flat. Indeed, the design of each one of them is well-nigh perfect; but what I want utterly and severely to condemn is the modern, ambulatory treatment of spinal caries. I think it probable that, after all the stir about the new treatment of hump-backs by forcible straightening has subsided, the chief beneficial outcome will be that every surgeon feels himself compelled to be far more careful in the adoption of patient and efficient prophylactic measures in the early days of the disease.

As I look back through many years of active hospital practice, I cannot divest myself of the thought that the plaster-of-paris jacket treatment (of which, I confess, I have been a warm advocate) must be held responsible for much of the existing deformity of Pott's disease. Many a time

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have I seen the angular protection coming on and increasing when the child had been getting about in a plaster jacket or some other form of support.

Though the child is to be lying flat for six, twelve, eighteen or more months he is not to be shut up in a close bedroom; the windows are to be kept open, and he is to be carried out every day into God's blessed sunshine—which is as necessary for warm-blooded animals as for plants; his muscles are to be maintained in good trim by massage, but he is to be kept all the time in the horizontal position. I know that in these days of activity and progress such unromantic treatment demands great confidence on the part of the parents in the judgment of the practitioner who insists upon it, but no little experience enables me with the utmost confidence to recommend it. Certainly it is not a new method. Hear what Sir Benjamin Brodie says upon the subject—this is the sentence at the very beginning of his valuable chapter on the "Treatment of Caries of the Spine." "From the first moment, therefore, in which the nature of the case is clearly indicated, the patient should abandon his usual habits, and be confined altogether on his bed or couch." *

Naturally one turns also to see what Percivall Pott has to say upon the question of the treatment of the disease which bears his honoured name. And it is somewhat of a disappointment to find him so taken up with the subject of the *Palsy of the Lower Limbs* which follows destruction of the bodies of the vertebræ, that apparently he has not the inclination to discuss general measures. But it is all delightful reading, and even to-day it is brimful of clinical instruction. What a relief it is to read a chapter or two of Pott, or Brodie, or Chassaignac after one has been poring over the pages of some modern text-book in order, as the saying is, to "keep abreast with the times!" Pott seems to put his red velvet sleeve around one's shoulders and to draw one aside from the bustling crowd of the "busy practitioners" (in whose peculiar interest modern text-books are quaintly said to be written), and to talk to one in the de-

* Observations on the Diseases of the Joints, 1850, page 342.

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lightful manner of those whose literary style has not been spoilt by the habit of counting words on telegraph forms or by compiling "copy" of precise length, and in a limited time for medical publishers!

However, Pott has a few pregnant remarks to make about the treatment of the later stages of spinal disease, but I am afraid that they will not prove quite acceptable to most modern surgeons any more than my own poor words on that subject may do. Still, it is a great pleasure to know that one is in good company the while! Pott is talking about the treatment by "spinal-supports" and "steel bodices," and, as I am telling you what he says, I feel his velvet sleeve leaving my shoulders and actually passing around my neck. He says that, though the use of these "pieces of machinery" is so general, and the vulgar prejudice in their favour is so great, he has long been convinced of their perfect inutility, and, moreover, that he is satisfied their effects are mischievous.

Speaking generally, the acceptance of a simple unromantic clinical method makes a far more serious demand upon the parent's or the patient's confidence than does the bidding of him to do some greater thing. This is understood and acted upon by the quack who, merely to create an impression, inserts in a lengthy prescription some rare and perhaps rubbishing ingredient which he thinks the apothecary will be unlikely to have in stock; who writes out a fussy dietary with unworthy attention to detail, and who, having failed to effect the promised cure, endeavours to preserve an unenvied reputation by sending his confiding patient to some far-distant watering place. In spite of education, people love quackery now just as much as they did in the time of Elisha, and, strange to say, the higher they are in the social scale the more they seem to hanker after it. The brief clinical record which have to the tuberculous lesion of the Syrian Lord Roberts admirably illustrates these points, for

> Naaman was wroth, and went away, and said, "Behold, I thought, He will surely come out to me, and stand, and call on the name of the Lord his God, and strike his hand over the place."

No; if he was to undergo the water-cure it certainly

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should not be in a muddy Israelitish stream; he knew of a couple of spas in Damascus which were really high class! "So he turned and went away in a rage." But being "a great man" he was not obstinate; so he changed his mind, followed out the instruction to the letter, and to his intense delight, attained the reward which sometimes falls to those who do exactly what their doctors tell them.

Here, so far as this Address is concerned, the clinical aspect of the case of Naaman ends, but it still contains an important lesson from a public point of view. For when the gallant officer found that his cure was complete he went straight to his good doctor—whilst the tear of gratitude was still in his eye—and begged his acceptance of a substantial and appropriate reward for the great service which he had rendered.

If during the unromantic treatment of spinal caries the weather is very bad and the patient has to be kept in his bedroom, the window should be open, and, if necessary and practicable, a fire should be burning—not a poisonous, parching gas-fire, however, as one finds in so many bedrooms. The condition of the bedroom of town-dwellers in England is a subject which greatly needs reform. The bedrooms in many London houses have recently become the recipients of a kind of back-wash of that unwholesome tide of æstheticism which was so much in evidence about twenty years ago. The walls are heavily papered and covered with fans, silly brackets and ornaments, dirty-looking hangings and rubbishing photographs. The table or chest of drawers is spread with an uncleaned cloth on which are arranged more photographs and dozens of nick-nacks—every one of which is a dust and germ collector. The furniture and window-hangings are heavy and the room is stuffy, dusty and teeming with germs of all sorts, I should think, and not improbably with those of tuberculosis.

Such rooms should be stripped bare, fumigated and washed; the walls should be distempered, and the floors should be treated to a weekly scrubbing. A small iron bed, a washstand and a couple of rush-bottomed chairs would be about all the furniture allowed. This does not sound artistic,

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I admit, but it is healthy, and it is better to be healthy than "artistic"; but art which is not subservient to intellectual and physical health is false and unwholesome.

When much of my work lay with out-patients, I used to have the children with spinal caries placed in the empty boxes in which oranges are imported. Such a box could be bought for a few pence, and an old blanket folded on the bottom of it served as a mattress. In the process of evolution the orange-box became for certain children a Phelps's box-splint. By some such means a child with caries can be carried from one room to another or taken into the open air without risk, and by slightly tilting up the box or tray the child can see what is going on around him, and thus he feels that he is not entirely excluded from the bustling world—the bright and sunny world in which his happy friends are permitted the enjoyment of work and relaxation.

Some years ago a man of about thirty was brought to me with the stiff, straight back, and all the other signs of lumbar caries. He lived close to a cricket-field, and it was early summer; so, having had him fitted with a rigid jacket, I told him to spend the whole day lying on his face and watching the games. Thus he was able to enjoy to the full those three essentials for the successful treatment of the disease, rest, fresh air and sunshine, and he made a complete recovery.

But supposing that the child with dorsal caries has been kept lying flat from the very first, the surgeon cannot even then promise that no deformity shall ensue, because the vertebral ulceration heals by granulation-tissue, which is ultimately converted into fibrous and osseous scar tissue. This, in consolidating, of necessity undergoes a considerable amount of contraction, which may suffice to draw the front of the vertebræ together. The more extensive the ulceration the greater is the amount of cicatricial contraction, and the more pronounced the deformity.

Here, in Eastern Canada, it would especially ill-become me to speak lightly of the value of cod-liver oil in the treatment of the disease under consideration, but perhaps I may humbly suggest that there are other remedies which may be

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looked to in the circumstances. As a matter of fact, I am a great believer in the value of the oil, but I would not, against his will, insist on a child taking a dessert-spoonful or even a tea-spoonful of it three times a day, as the manner of some is. So forced down, it is apt to upset the stomach as well as to cause diarrhœa, and it may then be found floating upon the surface of the dejections.

We are all apt to get too much in the habit of prescribing medical and dietetic treatment by routine, ignoring the fact that constitutions are not equally made to pattern. You have heard of that submissive patient for whom Sir Andrew Clark had laid down a very particular and strict regimen which ended up as follows: "And after dinner one cigar; not a strong one; a single Manilla cheroot." In answer to the illustrious physician's inquiry, a week later, as to how the dietary had answered, the unhappy patient, whilst replying that he was certainly better, pleaded to be let off the cheroot, which had invariably had the result of dispossessing him of his dinner. Possibly, however, after all, it was that cheroot which had played the most important part in effecting the gentleman's improvement!

Cream, butter, bacon and other fatty foods are all good for tuberculous patients, but I think that there is nothing quite so valuable as cod-liver oil. And if a patient assures me that he *cannot* take it, I often manage successfully to administer it after breaking up a conspiracy amongst his olfactory, optic and pneumogastric nerves. He probably confesses that he likes sardines; so, without his becoming aware of the trick, I have the preservative cotton-seed oil emptied away, and keep the sardine box filled with fresh cod-liver oil, of which every day he unconsciously takes a substantial amount.

For a tuberculous infant I order systematic inunction of the limbs and body with cod-liver oil every evening after the warm bath. I fully understand that this is apt to make the child "socially objectionable," but this is overlooked when the mother finds that he is improving and steadily increasing in weight.

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## PROPHYLAXIS.

The extermination-treatment of tuberculosis is a subject in which every member of the community should be encouraged to take a personal and intelligent interest. It is a great mistake to allow it to be regarded as merely "a doctor's question." And to wage a successful war of extermination the attack should be begun right early. It is a question which is of vital importance for the nursery, the school-room, the dwelling-house, the store, the office, the barrack—in fact it concerns every department and every period of life. The disease is everywhere, and its eradication is, therefore, a matter of concern to everyone.

It has not yet been shown that the offspring of tuberculous parents are born actually tuberculous, but it is beyond question that they are very prone to inherit a peculiar physical condition which renders their tissues an easy prey to the germs of the disease. The family history of many patients who at the threshold of life become the subjects of enlarged glands, or of chronic affections of the bones or joints, gives incontrovertible evidence of their being a marked hereditary disposition in the matter of tuberculosis.

So comes the question, ought there to be a law preventing those who are undoubtedly tuberculous taking upon themselves the responsibility of parentage? There are some who would answer this affirmatively and without hesitation. But what would the Church in general say to it, and what would the tuberculous curate in particular say to it? He would tell us that he reads in the very beginning of his Book that he is to "Be fruitful and multiply;" and, to do him justice, it must be admitted that in England, at any rate, he does his best to carry out this instruction to the very letter. But let him finish the injunction—Man was to be fruitful that he might *replenish* the earth. Now, though I do not claim to be in possession of peculiar knowledge on this point, I cannot think that the Great Architect of the Universe who "saw everything that He had made and, behold, it was very good," could have desired that this beautiful world was eventually to be stocked with so large a proportion of tuberculous rubbish.

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I am fully conscious of the fact that, in suggesting the desirability of preventing the marriage of tuberculosis persons, I am advancing a somewhat extreme measure; but surely the subject enters very largely into the question of prophylaxis. It is one, moreover, that will have to be deliberately approached and dealt with some day, and that, perhaps, soon. I do not think that our Houses of Parliament as at present constituted will be anxious to occupy themselves with an attempt to solve this question, vast as its imperial importance is, but I think that the County Councils, which we have lately established through England, might find the task not uncongenial. The question is fully as important as that of water supply, or of protection from fire, or of the isolation of infectious disease, each of which is already in their grasp. Indeed, I think that it falls in under the last heading. And what scope it would afford for discussion!

You will remember that when Horatio and Marcellus joined Hamlet on the platform after the appearance of the ghost, and showed great anxiety to know what had been the subject of his remarks, Hamlet tried to put them off by telling them that his communication had been something of a quite commonplace nature, on which Horatio ejaculated:

> There needs no ghost, my lord, come from the grave
> To tell us this.

I do not know what space the "perturbed spirit" had traversed in order to deliver his Address to the unhappy Prince, but I have travelled about four thousand miles to deliver mine. And if you feel inclined to suggest that there was no need for one to come so far to tell you that which I have just unfolded—that it is commonplace, and by no means worth my long journey or your short one—I shall conclude with Hamlet's retort:

> Why, right; you are i' the right;
> And so, without more circumstance at all,
> I hold it fit that we shake hands and part.

As a matter of fact, I have not, like the ghost, temporarily escaped for the purpose of this communication from a place where sulphur, burned in the open, is the ordinary domestic fuel, but I am here in response to a kind and highly

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flattering invitation from yourselves. I had, indeed, made arrangements for spending my autumn holidays, which certainly did not include two weeks of sea-sickness; but, when I received your President's command (for so I regarded your invitation), I at once scattered my personal plans and considerations to the winds and decided to accept it. And let me tell you that coming to Ottawa is not to me like going among strangers, though it is my first visit here, it arouses in me a feeling somewhat like that experienced by a man who is taking a homeward journey, for my father was a Canadian. From my infancy I have had pictured to me, and have been encouraged to interest myself in, your forests and rivers, your orchards and wide fields of waving corn, your green pastures and still waters, and your lingering snows (kindly notice that I have put the snows *last*). I have also constantly heard from my childhood of the intense loyalty of the peoples of this great and fertile country, and of the loving devotion of its sons and daughters to that dear Lady who is, indeed, a mother to us all.

Lastly, let me tell you that your complimentary invitation came to me just after those dark days of trial in which an ambitious, a cunning and an unscrupulous race had been endeavouring forever to overwhelm us. Dark, indeed, were those days; but darker still would they have been had we not known that your strong-limbed and keen-eyed sons were standing by us in our time of need! It is certainly not for a humble individual like me to presume, or to attempt, to say what the feeling of undemonstrative England may be towards Canada—I allude to this and to other circumstances only that you may in some measure see with what pride I accepted your invitation, and in order that you may more fully appreciate the sincerity of the thanks which I herewith tender you for thus directing my course to Ottawa, with an inclination eastwards to Nova Scotia—and to Halifax—where, in 1812, my good father was born.

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# Medical Society Proceedings.

## CANADIAN MEDICAL ASSOCIATION.

The "Century" Meeting, which was the Thirty-Third Annual Meeting of the Canadian Medical Association, took place in the Academic Hall, of the Ottawa University, Ottawa, on the 12th, 13th and 14th of Sept., 1900, Dr. R. W. Powell, the President, in the chair, and Dr. F. N. G. Starr, Toronto, Secretary.

The Minutes of the last meeting held in Toronto were read by the secretary and adopted.

Dr. DREWER, of Ottawa, presented the report of the Committee of Arrangements.

### THE PRESENT STATUS OF THE ELIMINATIVE AND ANTISEPTIC TREATMENT OF TYPHOID FEVER.

Dr. W. B. THISTLE, of Toronto University, read this paper. Some seven years ago he introduced this plan of treatment of typhoid fever to the profession. He claimed that this form of treatment for typhoid fever had time and again been misrepresented by Professor Osler and others, as he had never held to the opinion that the eliminative and antiseptic plan could rid such organs as the liver and spleen of the bacilli lodged in them. When once the typhoid bacilli gain access to the intestinal tract, the multiplication of them occurs with extreme rapidity, and the intestinal contents teem with countless numbers of them. These are not confined to the intestine, but are to be found in the walls, and in fact in almost every organ of the body. He was of the opinion that the draining of the intestinal walls following upon the action of a purgative either as calomel or mag. sulphate would tend to get rid of some of these bacilli in the intestinal walls, but he did not claim that it would effect their exit from the liver, etc. He thought the treatment had been imperfectly applied in many instances without a clear conception of the underlying principles. Under this plan of treatment Dr. Thistle has never had a single case of hemorrhage, what hemorrhage occurred having been always very slight. He has also had very few perforations—and twenty per cent. of the death rate is from perforation and hemorrhage. In Toronto this plan of treatment is universally adopted. Statistics at the Toronto General Hospital show that, from 1893 up to the present time, there have been 833 cases in that institution, with 56 deaths—a mortality of 6⅛ per cent.

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In discussing this paper Dr. McPhedran said that he had been watching Dr. Thistle's work in this direction from the time of the appearance of his first paper on the subject, but could not agree with all his conclusions. He did not think that this plan of treatment lessened diarrhœa, tympanites, fever or delirium. He considered that Dr. Thistle was harboring the idea that purgatives in typhoid were a new discovery with him; this was not so. Twenty-five years ago he (Dr. McPhedran) gave these for the first ten days at least. In addition to this he used to give carbolic acid and iodine, and in a certain class of cases he thought he had the exact treatment. Another class would then come along in which that treatment had no effect whatever. He considered that the general toxæmia that existed could not be eliminated through the bowel; it had to be done through the kidneys and skin.

Dr. Thistle, in his reply, emphasized the fact that he was *not* trying to eliminate bacilli from the glands; in clearing out the bowels he is trying to eliminate *toxins* from the body and not bacilli.

## A Case of Sarcoma of the Right Nasal Fossa with Acute Sinusitis and Orbital Cellulitis.

Dr. Perry G. Goldsmith, Belleville, Ont., presented this paper and patient. The patient was a man of thirty-eight years, a farmer with an unimportant family and personal history. He consulted the doctor on the fourth of August last with severe frontal headache and double vision. Examination of the nasal fossae revealed growths, which, along with some of the bone in the right fossa, were removed. After this swelling and pain in the eye began, so that it was seen to project far forwards, downwards and outwards. The right nasal fossa was curetted, the tissues being sent to Professor Anderson, of the Trinity Pathological Laboratory at Toronto, who pronounced them of sarcomatous origin, small, round cell variety, with the walls of the blood vessels thin and poorly developed. The discharge from the nostril was of an odor similar to that emanating from cancer of the uterus. Up to ten years ago Bosworth had collected forty of these cases.

Dr. R. A. Reeve stated that a number of years ago he had presented a paper before this Association on the same subject. He directed attention to the importance of examining the naso-pharynx in diseases of the orbit. He instanced a similar case to Dr. Goldsmith's. In his case there was little pain, but an examination of the nose revealed the tumor.

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### PRESIDENT'S ADDRESS.

On the afternoon of the second day, with a packed hall for an audience, Dr. POWELL delivered the annual Presidential address. He first recited a few reminiscences when on former occasions the Canadian Medical Association had convened in the Capital City, that was in 1871, 1881, 1889 and 1893. He made reference to the South African war in order to show the unsatisfactory condition of affairs which permitted other colonial surgeons from Australia and New Zealand practising their profession in that land without hindrance, whilst the Canadians were debarred from the same privileges. An earnest and united effort on the part of the profession throughout the whole Dominion of Canada in an endeavor to bring about inter-provincial registration would facilitate matters in the direction of securing these privileges for the Canadian profession in other parts of the British Empire. The hackneyed subject of tuberculosis was lightly touched upon; whilst a very important matter relating to the profession, that of a Medical Defence Association, was dealt with at considerable length. Dr. Powell favored the formation of such Association, and later on in the proceedings nominated a Committee to look into the question to report on the advisability and practicability of forming a Dominion Association of this character.

### SOME OF MY EXPERIENCES IN THE SOUTH AFRICAN WAR.

DR. GEORGE S. RYERSON addressed the Association on this subject. He dealt first with the experience gained of modern bullets. The very latest returns show that 986 officers and 11,701 non-commissioned officers and men had been wounded, of whom only 732 have died of wounds received in battle, which is to be ascribed to the aseptic character of the bullet and the prompt attention and antiseptic treatment. Dr. Ryerson then dealt with the wounds caused by these bullets. Referring to poisoned bullets b ing used, this was not the truth, as the tarnish or verdigris propably accumulated in transit through the barrel. He also doubted the fact of explosive bullets being used. The Boers made use of thousands of Martini-Henry, a heavy bullet, which caused great destruction of soft parts, necessitating amputation. There were few amputations in this war. He quoted Kendal Franks, who had performed 20 amputations in 2,000 cases. Whilst abdominal section in wounds of the abdomen was mainly inadvisable, he saw one case where the results were excellent. He spoke highly of the magnificent work of the R. A, M. C.

Dr. T. G. RODDICK, M.P., told of the great sacrifices of Dr.

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Ryerson in proceeding to South Africa at his own expense to carry out the work of the Red Cross Association. While in England recently, he stated he had made it his special business to enquire of returning Canadian soldiers as to the hospital management in South Africa, and, although he had spoken to many of these, he had failed completely to find a single Canadian who had anything but praise for the hospital arrangements in that country.

### Our Race and Consumption.

This was the title of a very able paper contributed by Sir James Grant, Ottawa, who considered it an important fact, and one worthy of consideration, that races had been born on this continent, had lived and entirely disappeared, leaving mounds in the West and other traces in Florida and elsewhere of their undoubted existence, and that thus far there was no information as to the exact cause of the disappearance of these races. He thought it remained for the Anglo-Saxons to see whether they will prove more successful than their predecessors in establishing themselves on this continent. He referred to the loss of 3,000 lives in the fair province of Ontario in 1898 by consumption alone, and deplored the fact that the people were not as yet alive to their danger. Sir James endorsed the legislation passed at the last session of the provincial parliament designed for the purpose of assisting municipalities in the erection and maintenance of sanitoria for consumptives.

### Recognition and Management of Tabes Dorsalis.

Dr. Allan McLane Hamilton, New-York prepared this paper, but on account of illness was unable to be present to read it. The President undertook this task. It appeared that, as an etiological factor, syphilis was not referred to by the early writers on this disease. While some would attempt to divide the symptoms of the disease into the leg and eye types, the writer would consider that to be unwarranted. He considered there was a close resemblance or rather relationship between the different forms of cerebro-spina sclerosis. There was no disease of the nervous system which had drawn forth so many plans of treatment; and but little or no good had resulted from any one thing. Most tabetics are favorable subjects for expectant treatment, and many derive temporary benefit from some new drug. Looking back over a number of years, he finds that most good has been accomplished where little or no medicine had been given. He has found rest by suspension and persistent cauterization of the back, good treatment. In the opinion of the writer, syphilis cannot be traced

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in more than fifty per cent. of the cases. For the arthropathies there is little to be done. Perforating ulcer is a rare feature of locomotor ataxia, and most obstinately resists treatment. He has seen three cases of this unusual condition in ataxics ; and the ulcer rarely exceeds two or three centimeters in diameter. One authority mentions five cases cured by means of nerve stretching. Through out the course of the paper numerous cases were cited with their symptoms and treatment.

### The Physicians' "Vaster Empire."

In this paper Dr. John Hunter, of Toronto, its contributor dealt with the questions of sanitary science, education, social purity and medical missions. Referring to sanitary science, he entered a plea for the broader and freer application of the principles of this branch of medicine, in the building and construction of our homes, schools, churches, theatres, etc. No dwelling-house should be constructed except under the supervision of an architect and a physician versed in sanitary science. In the matter of sanitary science architects had improved wonderfully during the past ten years. Another important question was that of our educational system—the mental and physical health and development of our school children. The best way to secure physical vigor and high mentality was surely within the province of the physician to grapple with and study. In all forms of social purity and impurity, physicians should speak *ex cathedra* against every form of vice and immorality. The boys and the girls of the family should be enlightened as to their sexual proclivities at proper periods by their fathers and mothers respectively. In medical missions he referred to the vast field for medical missionary work in foreign countries.

### Address in Surgery—Tuberculous Lesions from a Clinical Point of View.

The President introduced Mr. Edmund Owen in a few well chosen words. This address was delivered at the evening session of the first day, and the distinguished visitor was greeted by a crowded house. In commencing his masterly address, he stated that he would deal with tuberculous lesions as the surgeon meets them day by day in the hospital wards, in private practice or in the operating theatre. Referring to the pathologists, he considered his (the pathologist's) thought to be only of the dead tissue, while the surgeon sees the human tree during its life, and rarely follows it after death. The student does clinical and pathological work at different times, and he is enabled to follow the case straight from

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the ward to the laboratory. He considered that study of the fresh specimen was the best, for the specimen taken from formalin was no more like the condition than canned salmon was like fresh-run fish. He would not hinder experimental research work; it was absolutely necessary. The life of a man was of more value than a sparrow or many guinea pigs. It would be almost impossible to overestimate the direct value of experimental laboratory work. Strumous and scrofulous are now terms devoid of meaning, and we now call tubercle by its proper name. There are three great factors in connection with tuberculosis which the public must be made acquainted with: 1. The disease is communicable, but the public must be allowed a little time before they accept this statement and fact. 2. The disease is preventable; this follows almost as a corollary to the first statement. 3. The disease is curable. Years ago, the subject of tuberculosis was regarded as well-nigh hopeless, but now we do not consider it of the untractable nature that it was formerly considered. Tuberculous lesions are exactly what they used to be, and Mr. Owen has worked at the largest Children's Hospital in London for over a quarter of a century. We now take a much more hopeful view of these lesions. Many of you have studied tuberculous lesions under these skies, and also in the mother country. Do you find that the tuberculous lesions are the same in both hemispheres. One rarely hears now of the *vis medicatrix naturae;* surgery has rendered it superfluous. All have noticed cases of old standing hip joint disease where in time the boy actually grows out of his trouble. This may be a popular superstitution, but, like most erratic beliefs, it is founded upon a stratum of truth. In children these chronic diseases are always tuberculous. Where chronic abscesses occur it will not do to open and drain, but they must be scraped out, their unhealthy lining destroyed. In the treatment of these diseases, the learned surgeon stated that he had failed to find any virtue whatever in the employment of iodoform. It is an irritant and a poison, and it is apt to be septic, as germs can grow on it. Mr. Owen condemned the use of complicated apparata, and also the forcible correction in cases of spinal deformities. He considers that this deformity does not lend itself to operative treatment. There may perhaps be a small class of cases where it may eventually be found applicable, as where bone or organized inflammatory deposits press upon the cord so that the patient has lost movement in the lower extremities. The plaster of Paris jacket must be held responsible for much of the deformity of Potts' Disease. The proper treatment of these cases is rest in the horizontal position, with plenty of good

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fresh air and sunlight. At the conclusion of his extremely able and instructing address the thanks of the Association were moved in a complimentary speech by Professor Shepherd, of Montreal, and seconded by Professor Cameron, of Toronto, put by the President, unanimously carried amid great enthusiasm, and appropriately presented to Mr. Owen by Dr. Powell. Mr. Owen made a happy reply.

### Excision of the Knee Joint in Tuberculous Disease.

Professor Primrose, of Toronto University, minutely described Kocher's method of dealing with tuberculous disease of the knee joint, recited the histories of a few cases in which he had obtained excellent results where this operation had been employed. The steps of the operation were made clear by a blackboard drawing, and, at the conclusion of his demonstration, Dr. Primrose was highly complimented by Mr. Owen for his lucid exposition of his subject.

### Recent Pathologic Studies of the Blood.

The last paper on the evening of the first day was a most interesting and instructing one by Dr. L. H. Warner, of Brooklyn. At the commencement of his paper he asserted that he believed there was a necessity for experiments for the progress of pathology. His experimental researches were directed along three lines of enquiry, viz., experiments, observation and individual observation at clinics in hospitals. He considered that the examination of the blood in most cases was of more importance than an examination of the urine. Dr. Warner gave the formula of a new staining solution which he had found very practicable: The blood specimen should be prepared in the regular manner. The slides are heated in a hot oven to 98 degrees. Immerse for one minute in a one per cent. aqueous solution of methylene blue, washing in water, then in a one per cent. alcoholic solution of eosin, washing again with water, and then in a one per cent. solution of Bismarck brown. Dr. Warner's paper was illustrated with suitable diagrams.

### Some Experiences in the Treatment of Hernias.

At the morning session of the second day, Dr. F. J. Shepherd, Montreal, contributed the first paper. Some twenty years ago surgeons began to perform these operations by the open method. Older methods in vogue were touched upon and described, and he instanced one very large hernia which had come under his observation then where the man could not put his trousers on. The methods of operation are almost as numerous as

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surgeons, but there are certain general principles underlying all operations: 1. The necessity for excision or obliteration of the sac. 2. Closure of the canal. 3. Union by first intention. Some also held that alteration in the direction of the canal is necessary. The operation performed by Dr. Shepherd is Bassini's, but with it he is not always successful. He has used all kinds of sutures. Absorbable sutures are the best, and if antiseptic they are to be preferred. A suture that will last for three weeks is all that is wanted. He has used chromicized catgut now for some time. Professor Shepherd never washes out the wound, and thinks it better to dissect out the sac with the knife than to tear with it the fingers. He never uses a drain. For two years past now he has used rubber gloves in all his surgical work, abdominal in character, and he considers that he has got better results since beginning their use. In hernia operations the mortality is practically nil. Operations on children are now our most successful cases; formerly they were not advised except in strangulated cases.

Dr. Lapthorn Smith discussed this paper and the cases described, although his experience lay mostly in ventral and umbilical work. In some of these he had seen them so large as to require twenty stitches. During the past two years he has abandoned silk and resorted to catgut, chromicized, which he always prepares himself.

Replying to the criticisms, Dr. Shepherd stated if there was any oozing in the wound he would pass a probe in between the edges of the wound to let out the accumulated serum. This way he finds to be quite efficacious, as then you minimize the chance of the introduction of any germs from without.

## A Case of Syphilitic Gummata of the Spinal Cord Successfully Treated by Enormous Doses of Iodide of Potash.

Dr. F. W. Campbell, of Montreal, reported the history of this very interesting case. It occurred in a man of highly neurotic temperament who, a short time before the onset of symtoms of a definite character, had suffered from repeated attacks of insomnia of a very aggravated character. When his sickness began there were noticed retention of urine and loss of power in the lower limbs. Patellar reflex was about normal. The loss of power in the lower limbs was absolute. The pulse varied from 80 to 96; the temperature was never above 99. The stomach remained in fairly good condition all the time. A consultant from New York was brought on and a diagnosis established of tumor of

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the spinal cord situated about the first lumbar vertebra, which might be sarcomatous or syphilitic. The advice of the consultant was to give 500 grains of iodide of potash per day, commencing with a drachm three times a day. Dr. Campbell detailed minutely the daily history of the patient whilst getting him under the large dose, and then again whilst it was gradually being withdrawn. The patient is alive to-day and in good health, having recovered complete control of his lower extremities.

### Address in Gynecology.

A very practical address was that delivered by Dr. William Gardner, of Montreal, on the mistakes in diagnosing gynecological and obstetric cases. He states we often learn more from our mistakes than we do from our successes. Correct and accurate diagnosis depends mainly upon the sense of touch, which can only be attained by long and patient practice. He referred to the advantages of examining on a plain table instead of on a couch or bed. The patient's rectum should always have been emptied before presenting for examination. As for the bladder, it is best to empty that viscus yourself per catheter when the patient is on the table, as in this way you will be able to notice any discharges, etc. That the physician will have to do this often is quite clear, from the fact that there are many women of nervous temperament who would not be able to empty the bladder voluntarily in the physician's office. Another advantage of doing this for yourself is, that you get an uncontaminated specimen for examination. In cases where tension is present in the muscles of the abdomen, if you make a series of circular movements over the lower abdomen, gradually narrowing your circle, you will be able to overcome whatever rigidity there may be present. Dr. Gardner urged caution in the use of the uterine sound. He rather considers it a dangerous instrument, that its use ought to be extremely limited and holds the opinion that many women have lost their lives through this instrument. Then there is the danger and risk of infecting and injuring the uterine canal. This instrument, the uterine sound, is a great deal too much employed by the general practitioner. Mistakes in diagnosing displacements of the uterine body he considers the most common. The uterus is a very movable organ, and a distended rectum or bladder may cause it to be diagnosed as a retroversion. Then, it is important to remember that it may be displaced through acts of coughing, vomiting, etc. In all examinations of the pelvic organs, Dr. Gardner has made it a point to examine the position of the kidneys as well. Referring

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to examination by the Sim's method, it is necessary to have the patient in the proper position, and, if you have not a Sim's speculum, a bent table fork or the finger of the opposite hand may be used to distend the perineum. Mistakes are often made in the diagnosis of pregnancy, but still the patients are few in whom the diagnosis cannot be made by careful examination of history, signs, etc. Many women are probably inaccurate as to date. Dr. Gardner illustrated his points as he proceeded by reciting cases. One in particular he instanced where he once found a woman in his office on her hands and knees in the throes of a twin pregnancy, which a fellow practitioner had failed to recognize, and had tapped the gravid uterus, and had drawn a quantity of the liquor amnii. Dr. Gardner referred to the mistakes made by himself as well as by his brother practitioner. The close of the paper referred to an interesting account of mistakes which had occurred in diagnosing extra-uterine pregnancy. The Association voted him unanimously a hearty vote of thanks for his exceedingly practical paper.

### An Unnoticed Factor in the Production of Abdominal and Pelvic Disturbances in Women.

Dr. Clarence Webster, of Chicago, contributed an interesting paper with the above title. Symptomatology in women, he said, was often overlooked by the general practitioner. The question of the normal relationship of the abdominal and pelvic contents was dwelt upon, and then he proceeded to account for inter-abdominal pressure, holding to the view that the pelvic organs, as well as the abdominal, were to a large extent held in their respective positions by reason of the pressure of the abdominal and pelvic walls. He stated the average specific gravity of the viscera to be a little more than that of water; the liver was 1.5 sp. gr. He maintained that there was no proof that the mesenteries acted as constant supports or were ever meant to be such; and the main factor in sustaining the viscera is the strength of the abdominal wall and pelvic floor. Local weakness of the abdominal wall has been fairly well described under hernia, while general weakness of the abdominal wall has been described as pendulous belly. General weakness in his experience is an exceedingly rare condition. As to the question of etiology, the condition is found in women who have borne children; and so, on examination of the great majority of women, there is found some degree of separation of the recti muscles in the region of the navel. All evidence later on may disappear, but permanent widening remains. The results of all this is unavoidable enteroptosis; and this is generally found in women who

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have been addicted to the pernicious habit of tight lacing. A very common displacement seen is that of the right kidney. Dr. Webster dwelt upon the diagnostic symptoms of these conditions and then proceeded to describe the operation he performs for their relief. This consists in bringing the edges of the two recti muscles into apposition. He first performed this operation in Nov., '98. Since that time he has operated upon forty-one cases, and the results have been most satisfactory in all.

MR. I. H. CAMERON took exception to Dr. Webster using the word "unnoticed" in the title of his paper, as he thought this was not an unknown factor in the production of the conditions mentioned in the paper.

DR. W. S. MUIR, Truro, N.S., asked what effect leaving off the use of the binder after confinement had to do with the production of these conditions.

DR. WEBSTER held to the opinion that this had not been noticed except by himself, and challenged Mr. Cameron to quote authority otherwise. The absence of the binder, in his opinion, had not made any special difference.

## ADDRESS IN MEDICINE.

PROFESSOR S. F. SHATTUCK, of Harvard University, said, in opening his address, that the advance in knowledge had brought about our relation to things in general. There is noticed a subdivision of labor in every branch of industry. As a consequence, specialization has taken place in the science and art of medicine. In specialization lies the elevage between medicine and surgery; and nowhere has the line been more closely drawn than in England. Anesthesia greatly enlarged the bounds of surgery. Twenty-five years ago there was not a pure surgeon in America. Bellyache is now a surgical disease. The heart is practically the only viscus which remains the exclusive property of the physician; and he was not so sure that even this organ would not soon be attacked, and we might hear of suturing of the mitral valves. In this country the general practitioner is clinging to obstetrics for family practice. In some of the larger centres there is now even a tendency to specialism in obstetrics, where the specialist will preside at the accouchement, and the family practitioner then step in to oversee the attendance throughout the puerperium. Pure gynæcology scarcely exists to-day · and pelvic tinkering is suffering from a rapid decline. The great bulk of major gynæcology is nothing more than abdominal surgery, which properly belongs to the general surgeon. Gynæcologists should study general surgery and become general surgeons

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first. The field in medicine is so large that no one man can grasp it all in a lifetime. Other specialties were referred to. The desire on the part of some to escape the hurly-burly of general practice may be a cause in throwing them into special lines; and then there is the fact that special knowledge draws larger fees. Ophthalmologists get more for removing a speck of dust from the eye than the general practitioner. When we have specialists for diseases of the young, why not also have a specialty for the diseases of the old. In the belief of the distinguished professor from Harvard, specialism had come to stay. The gathering was exceedingly delighted with the deliverance of Dr. Shattuck, and at the close voted him a cordial vote of thanks, to which he made an appropriate reply.

### Gastric Hemorrhage.

This paper was read by Dr. George E. Armstrong, of Montreal, who believed there was a fairly well determined field in which surgical interference may be of use in hemorrhage of the stomach. Hemorrhage occurs in fifty per cent. of gastric ulcers and is fatal in eight per cent. Cases are arranged in two groups, the acute and the chronic. Rodman has reported thirty-one operations for frequently occurring or chronic hemorrhages, with six deaths. Dr. Armstrong has operated five times for gastric hemorrhage, one being a chronic case. In one of these the patient was getting along nicely after the operation, when she expired suddenly, and,on a post-mortem examination being made, thrombi were found in the branches of the pulmonary artery.

### Some Cases in Stomach Surgery—Gastrostomies, Two Cases; Gastro-Entrostomies, Two Cases; Pylorectomy.

Dr. A. E. Garrow, Montreal, reported these cases. In one patient operated on, the patient was fed before he left the operating table. Another, a woman of fifty years, who had a persistent hacking cough, had gastrostomy performed and discharged able to feed herself through a tube. In another case, in a man aged 33 years, who had vomiting and blood in the stools, the patient suddenly had acute pain with a pale face. Duodenal perforation was present; and when the abdomen was opened, gas escaped from the incision. When discharged on July 24th last, he was feeling well. Six cases were reported.

### The Modern Treatment of Retroversion and Prolapse of the Uterus.

Dr. A. Lapthorn Smith presented an able paper with the

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above title. It referred to the proper and most successful management of procidentia uteri in elderly women between seventy and seventy-five years of age—a most pitiable condition. Except for this trouble, she may be otherwise in excellent health; the perineum, however, is so relaxed that no pessary will remain in place. Then the majority of these cases have an ulcerated cervix. After confinement the uterus remained large and the pernicious habit of keeping women too long on their backs has a tendency to produce the backward displacement. Dr. Smith feels certain that women who have been relieved of this distressing condition will have little difficulty in persuading others to avail themselves of the treatment. He removed a woman's uterus a few months ago, which had been out of her body for twenty years; and the patient now assures him that she feels like a young woman. In correcting this deformity, Dr. Smith makes a small incision in the abdomen and performs ventrofixation. After that the vaginal canal is narrowed by a large anterior and posterior colporraphy. In selected cases, he also amputates the lower half of the organ and then stitches the vagina to the upper half. He considers ventro fixation, if properly performed, a most reliable means of fastening up the uterus. The operation has given him the most complete satisfaction of any operation he has ever performed, especially when combined with amputation of the cervix and posterior colporraphy.

### Gasoline as a Surgical Detergent.

A paper that was highly original was contributed by Dr. Bruce L. Riordan, of Toronto, on the use of gasoline as a detergent. With this dirty, greasy hands of machinists, who are the subjects of injuries in these parts, can be effectively and rapidly cleaned without the ordinary brush and soap and water. It is far better for this purpose than any method heretofore devised for cleansing. He now constantly carried a small bottle of this in his surgical bag. A report from Dr. William Goldie, Toronto, showed its effects upon germs and germ life, a report which would conduce to its employment as indicated. One word of caution was thrown out by Dr. Riordan in its use; as it is a highly inflammable substance, it should not be used in any quantity near an exposed light; and then it is painful in the eyes or ears. It is also useful in cleansing sutures of accumulated serum, blood and dressing powder, thus freeing these particles and enabling one to locate the stitches easier and quicker.

Dr. J. C. Mitchell, Inniskillen, Ont., stated that he had tried gasoline recently as a detergent in two very severe threshing-ma-

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chine accidents, where the parts were all smeared over with oil and grease and dirt, and it was very satisfactory, as he was able to get perfect cleanliness in a short time, both wounds healing by first intention.

### Dilatation and Prolapse of the Stomach.

Professor Alexander McPhedran, of Toronto University, presented this paper, which dealt principally with prolapse. This condition rarely occurs alone, but is associated with prolapse of other abdominal organs. There is generally present as well some degree of dilatation ; and the abdomen may be prominent or flat, or even retracted. The case of a man aged 51 years was referred to, a manufacturer, who had been ailing for two or three years. The stomach was below the umbilious. He was directed to massage the abdomen very thoroughly and to practice abdominal gymnastics. Through this treatment, combined with dietetics and some strychnine, he has been restored to health and able to resume business. Another case of a woman aged thirty-five years was reported. This woman had been the subject of recurrent attacks of vomiting for two years. The symptoms were detailed ; massage and abdominal gymnastics ordered with satisfactory results. The different ways of examining the stomach were described ; and, in concluding, Dr. McPhedran spoke of the benefits of a change of scene in treating these cases.

### Physical Training ; its Range and Usefulness in Therapeutics.

Dr. B. E. MacKenzie, of Toronto, gave a very interesting account of the methods employed by him in correcting deformities in his orthopoedic hospital in that city. The paper was illustrated by lithographs showing improvements in spinal deformities after physical training in the direction indicated. The paper embraced the results of his observations for thirteen years past, and was ample justification of the benefits derived from gymnastics in the correction of lateral curvature, club foot, etc. He had also found physical training valuable in hysteria and chorea, especially the former.

### Inter-Provincial Registration.

Dr. T. G. Roddick, M.P., read the report of the Committee having this matter in hand. A new feature to be incorporated in the measure was that of allowing the homœopaths representation on the proposed Dominion Council, as, according to the law of Ontario, these had their vested rights in that province, and so must

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be accorded similar interests in any proposed Dominion Council. These will be allowed three representatives, which will be equivalent to the representation from any one province of the Dominion. Their term of office will be four years. Homœopathy, however, as such, will not be inserted in the measure, but they will be classified under "any other school of medicine having legal recognition in any of the provinces in Canada," as the British Medical Council would not recognize any such body. Dr. Roddick stated that the Bill would be introduced at the next session, and advised the members of the Committee from each province to bestir themselves before their respective provincial parliaments, as these bodies must sanction the measure before it can be finally acted upon by the Dominion Parliament.

### Cerebral Abscess.

Dr. James Stewart, Montreal, reported two interesting cases of abscess of the brain situated in the tempero-sphenoidal lobe, and referred to the unusual existing aphasia which was present in both cases, viz., simple inability to name objects. The first case occurred in a young man of twenty-two years who had otitis media following an attack of influenza. Some six weeks afterwards an abscess formed. The abscess was diagnosed as being confined to this area simply on account of the peculiar aphasia— the simple inability to give the name of a pen when that object was presented to him. The patient was operated on by Professor Bell, who secured two ozs. of pus. Meningitis, however, set in and the patient died. The second case was a girl of 21 or 22 years of age. She had had ear trouble for a great many years, with very severe pain at times. She, too, had difficulty in naming objects, and she could not name any object whatever finally. She died suddenly a few hours before the operation was to be performed for her relief. On opening the skull at the subsequent *post mortem* examination, two abscesses were found, one skirting the upper margin of the lobe, and the other situated about the center thereof.

In reply to a question of the President, whether we were to take this kind of aphasia as a distinct diagnostic symptom of abscess in that region, Prof. Stewart stated, there is what they call a "naming centre," and, when this is destroyed, that particular form of speech defect is present. The cases were aptly illustrated by a diagram.

### Gangrene of the Leg following Typhoid Fever.

Dr. H. H. Chown, Winnipeg, reported two cases of gangrene

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of the leg following typhoid fever, which had recently come under his observation. In the first case the patient had the charactaristic symptoms of typhoid fever, the spots appearing at the end of the first week and being very numerous. Great pain set in in the calf of the leg, with collapse symptoms, while the limb was cold and bloodless. Cutaneous sensibility was lost over the leg. The third day after the complication set in the part involved included the lower third of the leg on the inner side and the lower half on the outer. Operation was done at junction of upper and middle third of femur. Patient stood the operation well. The temperature before the operation was 102.6; pulse 120. On the following day the temperature was normal and the pulse 110. On the tenth day the flaps were united. There was a rise of temperature a few days later—a relapse, with hypostatic congestion of the lungs. On the fifth day after there was hemorrhage of the bowels. The patient is now a picture of health, weighing 200 lbs. The second was a somewhat similar case in which the blood reacted early and promptly to the widal test. The gangrene began in the first case on the 11th day of the disease; in the second on the ninth. Keen reports gangrene on the 14th day. The gangrene in the second case extended to the upper and middle third of the leg. The leg was amputated and prompt union took place throughout.

Dr. R. B. NEVITT, Toronto, discussed these cases, and mentioned a similar case coming under his observation during the past summer. Gangrene occurred in his case about the third week of the fever, and the patient was seen about a week or ten days thereafter. Amputation was performed through the middle third of the femur. He also referred to a case of gangrene of the arm following an attack of pneumonia, recently observed by him.

## NOTES ON ATROPINE.

An interesting paper was that contributed by Dr. R. D. RUDOLF, of Toronto University, which was illustrated by means of a chart showing the action of the drug on animals and the inferences drawn therefrom of its therapeutic uses. He finds that the drug directly stimulates the heart, and thus the blood pressure is markedly raised. He considered that the maximum single dose as laid down by Witherstine of 1-20th of a grain as too large unless used as an antidote, and thinks that we ought never to give more than 1-100th of a grain of atropine sulphate at one time, except in emergencies. He also referred to its action in catarrhal pneumonias of children and its employment before anesthesia to ward off danger.

The paper was discussed by Dr. A. D. BLACKADER, who con-

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gratulated Dr. Rudolph upon it, and said that he hoped he would pursue his studies farther upon the same subject to find out the effect it would produce in controlling vomiting after anesthesia. He considered, however, that strychnine and not atropine was the most powerful heart tonic in our possession. He thought that late experiments would throw doubt upon atropine being a direct stimulant to the heart muscle ; and he thought it would be questionable practice to administer a drug when we wanted to stimulate the heart's action that would paralyse nerve endings.

### Lantern Slide Demonstration of Skin Diseases.

The demonstration of these cases was conducted by Dr. George A. Fox, of New York City, and it proved to be one which the members of the Association thoroughly appreciated. The great majority of the skin lesions shown were of syphilitic origin; and, as they appeared on the canvas, Dr. Fox described the histories of the cases. One in particular is remembered from the disfigurement of the woman's face. It was a large mass of excrescences on the nose, which Dr. Fox was able to get rid off in the course of two or three months, leaving only a slight superficial scar. He laid down a timely word of caution in treating syphilitic conditions, that, when the patient was run down and emaciated, through large doses of mercury or iodide of potash, not to keep on pushing these drugs, but to desist for a time, and in the interval endeavor to build up the patient's strength and general condition. That accomplished, return to the specific treatment, and the results would be found to be more beneficial. At the conclusion of the doctor's demonstration, which will rank as one of the features of the meeting, Dr. Fox was voted a cordial vote of thanks for his instructing work.

Dr. F. J. Shepherd showed a very interesting case, a boy of sixteen years, who at the age of six sustained a severe cutting injury of the nerves and vessels of the axilla. All the nerves of the brachial plexus below the cords of the brachial plexus being severed completely. At that time, ten years ago, Dr. Shepherd dissected out each nerve separately and united their respective ends by suture. All did well with the exception of the musculo-spiral, and as a consequence, the lad exercises very little control over the extensors of the forearm.

### The Successful Treatment of two Important Cases of Disease of the Eyes by the Combined Methods of Mercury and Iodide of Potash Internally and Pilocarpine Hypodermically.

Dr. G. H. Burnham, Toronto, reported two cases successfully

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treated by his combined method. Under this method no such result follows in other plans of treatment, and with this plan a permanent result is got. This treatment has a wide application. Whether iodide of potash or mercury or the iodide alone be given internally in suitable cases without satisfactory results, if the pilocarpine be added, good results will always follow.

### Mental Sanitation.

The assistant superintendent of the Brockville Asylum for the insane, Dr. R. W. Bruce Smith, contributed a scientific paper with the above title. It was a plea for prophylaxis in insanity, and he thought that much would be accomplished in this direction during the twentieth century. Insanity was on the increase in Canada, and it can be ascribed to the fact that, while these unfortunates are well attended when they become insane, the fact that there have been no preventive measures employed speaks for itself. In order to accomplish good in this direction, we must seek either to lessen the demands on, or to strengthen the resisting power of the brain. He condemned inter-marriages in families, and also amongst those of a deranged mentality. Fifty per cent. of the cases of insanity were hereditary, and the descendants of these should be careful in contracting marriage ties. He referred to a portion of one county in Ontario alone, where indiscriminate marriage and inter-marriage has become most fruitful; and he has seen several members of one family from that locality inmates of the same institution at the same time. He considers that the day may yet dawn when we will give the same attention to the rearing of children as we now give to the breeding of horses. Speaking of farm life and the tendency it has to melancholy, he thought this class of the community should receive education in participating more in the enjoyments of life and not to continue to rot in domesticity. An upheaval in the sentiment and surroundings of the rural homes would work wonders in prophylactic principles.

The Canadian Medical Association endorsed the scheme for the formation of a Dominion Anti-Consumption League. The following were recommended as provisional officers: — President (Honorary), The Governor-General; President, Sir James Grant, Ottawa; vice-presidents were appointed for all the provinces; the secretaries are to be the secretaries of the different provincial boards of health. Secretary-Organizer, Rev. Dr. Eby, Toronto; Treasurer, J. M. Courtney, Esq., Deputy Finance Minister, Ottawa.

### Re Medical Defence Association.

The Association recommended that Dr. V. H. Moore, Brock-

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ville, be the permanent Chairman. One member for each province was appointed. This Committee will gather information on the subject and bring in a recommendation at the next annual meeting.

The Treasurer's report showed that 153 members were in attendance, and that there was a balance in the treasury of $240.65.

### Election of Officers.

Next place of meeting, Winnipeg.—President, H. H. Chown, Winnipeg; Vice-President, P. E. I., H. D. Johnson, Charlottetown; Vice-President, N. S., A. J. Maiter, Halifax ; Vice-President, N.B., T. D. Walker, St. John ; Vice-President, Quebec, A. Lapthorn Smith, Montreal ; Vice-President, Ontario, A. A. Macdonald, Toronto ; Vice-President, Manitoba, J. A. Macdonald, Brandon ; Vice-President, N. W. T., J. D. Lafferty, Calgary ; British Columbia, S. J. Trinstile, Vancouver ; Treasurer, H. B. Small, Ottawa ; General Secretary, F. N. G Starr, Toronto.

Sir William Hingston and Dr. F.W. Campbell, Montreal, were appointed on the Board of Governors of the Victorian Order of Nurses as representatives of the Canadian Medical Association.

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# Editorial.

## THE CANADIAN MEDICAL ASSOCIATION.

The Thirty-third Annual Meeting of the Canadian Medical Association, which was held in the City of Ottawa, on the 12th, 13th and 14th of September, was among the most successful which the Association has had; nearly one hundred and sixty members registered. The number of papers read and their general character was, if anything, greater in number and superior to any presented at prevous meetings. Moreover, the attendance was well kept up, even at the last meeting held on the afternoon of the 14th inst.

The address on surgery, by Mr. Edmund Owen, of London, England, who came to this country specially for this purpose, was the treat of the meeting. Couched in the most beautiful English, and delivered with more than usual oratorical force, it held the large audience spell-bound up to its close. Of its eminently practical character we will not write, as we publish it in full in this issue.

The address on medicine by Dr. Shattuck, of Boston, was also a scholarly production, and was much appreciated. Dr. William Gardner, of Montreal, gave the address on gynecology, which gave full evidence that he fills a prominent place in that field of practice.

The hospitality of the professors in Ottawa was un-

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bounded, and all present bore away with them feelings of the very warmest regard toward their hosts. The details of this hospitality consisted of an electric car ride to Britannia on the Bay, a most delightful spot on a warm day; also a dinner at the Russell House, and lastly a car ride through the city and out to Rockcliffe Ranges, where a most sumptuous lunch was served in the handsome new building just erected by the Dominion Rifle Association. The Staff of the Protestant Hospital also entertained at lunch those whose time permitted them to visit that institution.

Winnipeg has been selected as the next place of meeting, and the time most likely will be about the middle of August. If the officers of the Association can secure from the Canadian Pacific Railroad terms as good as they got when the Association met in 1889 at Banff (including special rates to the Coast), there is every reason to look forward to a very large attendance.

## SIR WILLIAM STOKES, M.D., F.R.C.S.I.

The late Sir William Stokes died at the base hospital at Pietermaritzburg, South Africa, on the 18th of August last. Among the large number of medical men employed at the seat of war, no death which has occurred among them can in importance be compared to that of Dr. Stokes. This gentleman was the son of William Stokes, whose splendid works on Diseases of the Heart and Lungs are still read by every educated physician, and whose kindness to the writer when on a visit in 1861 to Dublin has always been green in his memory. Sir William was appointed consulting surgeon to the forces in South Africa on 29th of December last, and arrived at the Cape about the first of March. He at once proceeded to Natal and took up his duties at the General Hospital at the Mooi River. These duties were most harrassing in their nature, but, like a true surgeon, he was happiest when doing his best to relieve suffering and save or prolong life. But the surroundings were not of a nature to suit a constitution never very strong, and rendered distinctly weak by some months of great mental anxiety owing to serious illness in his family. He was also troubled with a chronic winter

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cough. When we take these facts into consideration, we can see the courage of this brilliant and loyal Irishman in facing the onerous duties in the field in South Africa. Sir William was beyond any question the leading Irish surgeon, and was in his 62nd year at the time of his death. He was Surgeon-in-Ordinary to the Queen in Ireland, President of the Royal College of Surgeons, Ireland, and Surgeon to the Meath Hospital, Dublin.

## UNITED STATES MEDICINE.

Dr. Jacobi, of New York, read before the late International Medical Association, in Paris, a paper on what he terms "American Medicine" (we have styled it United States Medicine). This paper has been adversely criticised as being too apologetic in its tone, and having read it we are inclined to agree with its critics. Dr. Jacobi is a well-known figure in United States medicine, and is generally held in high esteem. But, although he has resided a great many years in New York, we fancy that some of his European ideas have not been entirely brushed off. In writing of the Medical Schools in the United States he says, "Of the 156 Medical Schools, which exist at the present time, 3 date from 1765 to 1800, 12 from 1801 to 1825, 22 between 1826 and 1850, 33 between 1857 and 1875, and 86 since." He adds "How many more have been so good as to disappear from the face of the American (United States) earth nobody cares to learn or know. If we knew we should shed no tears."

## THE LONDON BRANCH OF W. B. SAUNDERS & CO.

W. B. Saunders & Company, of Philadelphia, the well-known Medical Publishers, announce that they are about to establish a branch of their business in Great Britain. Mr Saunders has recently spent several weeks in London, where all the arrangements preliminary to the opening of an English house have been completed.

This London branch will be operated in immediate connection with the home establishment in Philadelphia, and

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the same methods that have been so successful in building up the business in the United States will be employed in the conduct of this new branch.

The details of the various departments of the firm's affairs have now been developed to such a state of perfection that the House feels the time has come for extending its field of operations. For a number of years Saunders' books have been sold in England through the agency of a London publisher, and, although they have already met with remarkable favor, the House is confident that by applying to the English market the same policy that has proved so successful at home, the sale of its publications in Great Britain and her colonies can be enormously increased.

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## PERSONAL.

Dr. E. P. Lachapelle, President of the Provincial Board of Health of the Province of Quebec, and President of the College of Physicians and Surgeons Province of Quebec entertained Mr. Edmund Owen, the well-known London, Surgeon at lunch at St. James Club on the 15th September. The guests present were Dr. Craik, Dean of McGill Medical Faculty; Dr. Rottot, Dean of Laval Medical Faculty; Dr. F. W. Campbell Dean of Bishops Medical Faculty; Dr. Powell (Ottawa), Ex-President of the Canadian Medical Association; Dr. Roddick, M.P.; Dr. Gardner, Dr. Benoit and Dr. Lafleur.

Dr. Fuller, of Sweetsburg, was in Montreal on September 20th, and visited several of his friends.

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# Book Reviews.

**A Manual of Personal Hygiene.**—Edited by Walker H. Pyle, A.M., M.D., Assistant Surgeon to Wills Eye Hospital, Philadelphia, Fellow of the American Academy of Medicine. Contributors: I. W. Courteney, M.D., George Howard Fox, M.D., and several others. Illustrated, Philadelphia W. B. Saunders & Co., 1900. J. A. Carveth & Co., Toronto, Canadian Agents. Price $1.50.

The object of this manual is to set forth plainly the best means of developing and maintaining physical and mental vigor. Throughout the book there is concise but adequate discussion of the Anatomy and Physiology of the parts under consideration, upon which is based the advice given. In other words, there is an exposition of proper living upon a physiological basis. Purely technical phraseology has been avoided, as far as compatible with the scientific value of the text, and numerous explanatory diagrams and illustrations have been introduced, Although each chapter is complete in itself, there has been purposive repetition of remarks upon subjects of such general interest, as eating. drinking, breathing, bathing, sleep, exercise, and in order that they may be discussed more throroughly from several standpoints. .The style in which this manual is written is very pleasant, and no one could rise from its perusal, or of any part of it, without absorbing a very large amount of must valuable information. As a text book, it should find an entrance into all schools where Hygiene is taught, and the general public will find it well worthy of perusal. It is a sad commentary on human nature, that so few really know how much they can do to make their lives healthy and in this way prolong life. Even the medical professor is not guiltless in this respect. This book deserves a very wide circulation.

**Progressive Medicine.**—A quarterly Digest of advances, discoveries and improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia, etc., etc., assisted by Charles Adams Holder, M.D., Assistant Demonstrator of Therapeutics in the Jefferson Medical College. Vol. III., September, 1900. Diseases of the Thorax and its Viscera, including the Heart, Lungs and Blood Vessels, Diseases of the Skin, Diseases of the Nerve System, Obstetrics. Lea Brothers & Co., Philadelphia and New York, 1900.

This volume has appeared very promptly on time, and is equally as valuable as any of its predecessors. The departments in this volume have been collated by such well-known men as William Ewart, M.D., F.R.C.P., Henry W. Stelwagon, M.D., William G.

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Spiller, M.D., Richard C. Norris, M.D. Every practitioner who desires to keep up with the rapid advance the profession is making should subscribe for this publication, beautifully bound, which is issued every quarter. F. W.C.

**Medical Diseases of Infancy and Childhood.** By Dawson Williams, M.D., London, Fellow of the Royal College of Physicians, London, and of University College, London; Physician to the East London Hospital for Children; second edition revised with additions by Frank Spooner Churchill, M.D., Instructor in Diseases of Children, Rush Medical College, in affiliation with the University of Chicago; Professor of Pediatrics, Chicago; Polyclinic. Illustrated with 72 engravings and two colored plates. Lea Bros. & Co., Philadelphia and New York, 1900. Cloth, $3.50 nett.

There is no class of patients who appeal more strongly to the physician and surgeon than those who come under the designation of infants and children. This is due to two causes, viz.: 1. They form a very large percentage of those they are called upon to treat, and are of immense importance, therefore, from a pecuniary sense. 2. The very helplessness of infantile life, depending almost entirely on objective symptoms for elucidation of its diseases, appeals with much force to the better nature of the profession. Yet, strange to say, up to twenty years or so ago in this country no special attention was given to diseases of infancy. The consequence was that young graduates felt themselves at sea when confronted with an infant, unable to tell its tale of woe except by signs which speak to experienced eyes well-nigh as well as words. How different it is now? With special professors in every Medical College, and an extensive literature on the subject, these little sufferers receive vastly better treatment and care. Among the numerous works which have of late years appeared devoted to diseases of infants, that of Dr. Williams, of London, has occupied a prominent place. The present American edition, edited by Dr. Churchill, is decidedly of more value than the original London edition, inasmuch as it brings the work up to date, and represents also in addition, enclosed within brackets, the views of the leading physicians of the United States. There is a very valuable chapter on infant feeding, in which the views on this subject held on this continent are very clearly and concisely stated.

The work is one that should be in the hands of the general practitioner, and we commend it to them as a most valuable book.

F. W. C.

**Elements of Clinical Bacteriology.** By Dr. Ernst Levy and Dr. Felix Klemperer, of the University of Strasburgh. Translated by Augustus A. Eshner, M.D. Published by W. B. Saunders, Philadelphia, 1900.

This is the authorized translation of the second edition of this well-known work—well-known in Germany, and deserving to be better known here. A work by one German is usually imposing

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enough, but, when three of them have had a hand in it in two languages, it is apt to be a fine affair. Even the works on medicine, which endure, are those which possess style. Facts are not enough, and a laboratory is not a good place for the cultivation of the literary quality. That is why so many of the recent books on bacteriology will pass away. This book will not pass away, because, while this artistic quality is absent, it contains a full and plain record of thorough work set forth according to a plan and easily accessible by means of a good index. A thorough test of the book warrants the statement that it contains all that a reasonable person requires to know upon the subject with which it deals. Matters, not yet decided, are discussed in a temperate way, and the authors do not try to prove too much. One who reads all of Mr. Saunders' publications, and they are all worth reading, seizes with joy upon the pictures that have now become so familiar by their continual reproduction. That admirable exercise in prespective, "The Boy filling the Tubes," originally drawn by Kaula, is much missed in the present work.

A. M.

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# PUBLISHERS DEPARTMENT.


## SANMETTO IN SENILE IMPOTENCE, AND AS A GENERAL REMEDY IN GENITO-URINARY CONDITIONS AND COMPLICATIONS.

Sanmetto has, during the past few years, pleased me very much, particularly in senile cases, where impotence was and had been pronounced for years. As a general remedy in genito urinary conditions and unpleasant complications accompaning these cases, the results are, in the majority of cases, very satisfactory. Chas. E. Bennett, M.D., 1876, Detroit School of Med.; Mem. Am. Med. Assn., Ohio State Med. Soc., late Pres. Fulton Co. (Ohio) Med. Soc., Surg. L. S. & M. S. R. R., Wauseon, Ohio.

## SANMETTO IN CYSTITIS AND PROSTATITIS—ALSO IN GRAVEL.

I used a bottle of Sanmetto upon myself. I was suffering with cystitis and prostatitis and received some relief. I think by continuing its use will effect a cure. My age is sixty-five years, not so easily cured as younger persons. We have a man in town by name J. S. K., who had been suffering with gravel for years and had spent much with physicians. He used Sanmetto, and it would be hard to believe the amount of calculi that passed in a few days; in fact it was disintegrated and passed so rapidly that he was forced to stop the medicine for several days. If desired, he will report the case himself. J. Y. DeShong, M. D., Judsonia, Ark.


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CANADA
MEDICAL RECORD

OCTOBER, 1900

# Original Communications.

## SYPHILITIC GUMMATA OF SPINAL CORD TREATED SUCCESSFULLY BY VERY LARGE DOSES OF IODIDE OF POTASH. *

By FRANCIS WAYLAND CAMPBELL, M.A., M.D., C.M., L.R.C.P., London, D.C.L.

Dean of and Professor of Medicine, Faculty of Medicine, University of Bishop's College, Montreal.

The notes of the following case have, for obvious reasons, not been hitherto published. I do not propose now to do more than briefly outline the salient points of the case.

A few years ago I was consulted by R. C. S., who, for the previous 15 years, had been general financial manager for a large manufacturing firm, while, at the same time, he held an interest in a factory outside of Montreal, for which he also did the financing. His family history is highly neurotic, his mother having been extremely emotional and hysterical, dying from softening of the brain. She was subject all her life to chronic diarrhœa, which was always aggravated under anxiety, joy or grief. To her family she communicated her temperament in a very marked degree. The patient had always been well developed, strong and hearty looking. About three years previous to the present attack he suffered from insomnia, which resisted every remedy prescribed. He was under treatment for about three weeks, and never got more than two hours' sleep upon an occasional night. I ordered him to Old Point Comfort, and, on the first night of his arrival, he slept for ten hours. His improvement there was rapid, and after a sojourn of a month

* Read before the Canadian Medical Association, Ottawa, Ont., Sept. 14, 1900.

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he returned home in perfect health. From this date till he consulted me for the present illness, he continued well, and performed all the duties pertaining to the position he occupied. He consulted me on April 1st for a pain which he felt over the region of the right kidney, and the following day I was called to see him at his house. I found him complaining of the same pain in the same region, which was severe and spasmodic. It was neither increased nor diminished by pressure. A hypodermic of Battley gave some relief. He was ordered a mixture containing five grains of iodide of potash and twenty minims of wine of colchicum to each dose, upon the idea that the pain was neuralgia of a gouty character, the patient's habits being free. This gave him very considerable relief, and in eight days he was able to return to work. From this up to the beginning of August his health seemed fairly good. I met him occasionally on the street, when he said that at rare intervals he had a feeling of numbness in his feet, particularly his right. Soon after, I went to Europe, and during my absence he consulted my friend, Dr. Perrigo, for a somewhat persistent numbness in both feet and legs, and a want of sensation in the rectum when a motion was passing, though he had perfect control of the sphincter. Under the medicine prescribed he made some little improvement. On my return, the end of September, his wife being ill, I saw him occasionally. They were living at one of the summer resorts near Montreal. He said that the pain had returned, and was, at times, very severe, while he felt sure the numbness was increasing. He promised to place himself under treatment when the family returned to the city. Soon after he received a severe mental shock by the burning of the factory, in which I have already said he was interested, and by which fire he lost heavily. For some days afterwards he was quite unfit for work, and the pain and numbness markedly increased, evidently due to nervousness, as they both improved by simple rest. Early in October I was called to visit him at his house for intense pain again over the kidney. It required two hypodermics of Battley's solution gtt xx in each, given an hour apart, before he got even partial relief

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These had to be repeated for several days, but, under the mixture of iodide of potash and colchicum, which was again prescribed, he was at his office toward the end of the month. He then left the city on a week's business trip, which was fatiguing both mentally and bodily. The day following his return, November 9th, I was sent for to relieve the same pain. Hypodermics of Battley were useless, and I got him under the influence of opium by giving it by the mouth, and he gradually got ease. On the 15th of November he was so much better that a trip to Nassau was arranged for. Up to this time he did not complain of any increase of numbness in the feet and limbs, and he had perfect control over them. On the 22nd November the pain returned, and opium was given in full doses by the mouth. In the early morning of the 26th November I was called for the purpose of drawing off his urine. I attributed its retention to overdistension due to a blunted sensibility caused by the large amount of opium he had taken. In the forenoon the late Dr. R. P. Howard and Dr. Perrigo saw the case in consultation. We then noticed for the first time a distinct loss of power in the lower limbs. He was, however, able to get out of bed unaided, but, when seated on a chair, it required a determined effort to cross them. The patella reflex was about normal. Irritation of the soles of the feet showed slightly diminished reflex action while the patient was seated on a chair. When lying in bed the reflex action was normal. The diagnosis was some affection of the cord, but no absolute diagnosis was made. Patient put on ten grains of iodide of potash three times a day. Two days later the loss of power in both limbs was absolute. The paralysis of the bladder continued, and, a trained nurse being placed in charge, the urine was withdrawn four times in the twenty-four hours. From the commencement of the illness the pulse has varied from 80 to 96, and the temperature has never risen above 99. Notwithstanding the large quantity of opium which had been taken, the stomach remained in fairly good condition. On December 1st severe lightning pains were felt in both limbs, but the pain over the region of the kidneys had not been felt for several days. The

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bowels constipated and considerable tympanites, relieved at times by passing flatus. Paraplegia still continues. The friends of the patient suggested bringing on some well-known specialist on Diseases of the Nervous System from New York, and I selected Dr. Seguin. On December 5th this gentleman met myself, the late Dr. R. P. Howard and Dr. Perrigo. After hearing my notes of the case he made a thorough examination of the patient, and gave it as his opinion that we had to deal with a tumor of the spinal cord situated about the first lumbar vertebrae. Its nature might be sarcomatous, but he was inclined to consider it syphilitic, although I had not been able to make out a specific history. I may say that subsequently I was able to satisfy myself that Dr. Seguin was correct in his opinion. His advice was to push iodide of potash to the limit of five hundred grains a day, commencing with a drachm three times a day, and increasing the dose by thirty grains daily. It was to be taken in Vichy water, two bottles daily, half the dose being dissolved in the contents of each bottle, and used as a drink. If, within the following two weeks, there was not any improvement, he thought the issue would be fatal, unless the spine was opened and an exploratory examination made. If the diagnosis was confirmed, he would then advise that the spine be further opened and the tumor removed. Although this operation had never been performed he strongly advised it, and believed the prospect of success was good. Dr. Weir, of New York, had expressed his determination to perform such an operation when a suitable case presented itself, and Dr. Seguin believed such a case was the present one.

*Same day*, 10 *p.m.*—Lightning pains in both legs all day. Spots of non-nutrition; bed sores are evident over maleolus and heel of left foot, and at several points on right foot and leg. Fifteen minims of Battley gave a fair night's rest.

*December 6th.*—Bed sore over sacrum threatening, and the patient was ordered to lie as much as possible on either side. Non-nutritious spots on leg decidedly increased in size. Lightning pains in both legs at intervals—urine has still to be drawn off.

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*December 9th.*—Under the influence of Battley's solution patient has slept fairly well. The lightning pains or jerks in legs are almost gone. Threatened bed sore on back no worse, and the same may be said of the threatened sores on the legs. Had a natural motion.

*December 12th.*—Says he feels a more natural feeling in both legs. Spots on legs improving, but bed sore on back is worse, as he has not been able to rest on his sides nearly as much—a slough is threatening. Complains that he feels most uncomfortable at the rectum, and that a motion would relieve him. He was given a large injection of soap suds and olive oil, which came away without any fæcal matter. On examination the rectum was found loaded with fæces, which was removed by the finger, giving great relief. Patient is now taking 240 grains of iodide of potash daily; no acne or nasal irritation.

*December 15th.*—As stomach is somewhat irritable (he has been taking light diet freely and digesting it well) the iodide of potash was discontinued. Has not had any motion since fæces were removed on the 12th, so the rectum was again emptied by finger, the fæces being softened by hot soap suds and olive oil.

*December 18th.*—Patient feeling better, spots on legs show decided improvement, bed sore on back has sloughed and was dressed. Iodide of potash, which was stopped at 300 grains, was to-day resumed at same dose.

*December 22nd.*—For the first time there is a movement perceptible in the toes of both feet, and the bladder shows signs of returning power by forcing the stream about an inch from the catheter. Non-nutritious spots on legs rapidly disappearing. Bed sore on back improving.

*December 25th.*—Patient in good spirits. There is a decided improvement in left leg, which to-night he was able to flex, raising popliteal space three inches from bed. Made a vigorous but unsuccessful attempt to do same with the right —movement in toes of both legs is very marked. Is now taking 400 grains of iodide of potash. The increase in dose from 300 grains has not been so rapid as up to that point.

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*January 1st.*—Legs continue to improve; is able to flex left considerably, right slightly. Bed sore improving.

*January 7th.*—Non-nutritious spots disappeared entirely, legs improving slowly. Is able to raise both legs several inches off the bed, marked movement in toes. Is now taking 500 grains of iodide daily; two doses of 250 grains are dissolved morning and evening in a bottle of Vichy, and he sips it when wishing to relieve thirst.

*January 10th.*—Legs still improving and gaining in strength; is able to move them about the bed. Had a natural motion and passed water three times to-day.

*January 16th.*—Up to this date patient has been steadily improving, but towards afternoon became very restless, and complained of a sharp shooting pain down the left leg. Complained also of pain in right buttock, where I detected deep seated; fluctuation, ordering it to be poulticed. Temp. 102½, pulse 120.

*January 17th.*—Passed a restless night; refuses food, but temp. has fallen to 101 F., and pulse to 110.

*January 20th.*—Patient has had bad nights; opened abscess on right buttock, getting fully 8 ounces of matter. To-night, temperature has fallen to 99 F. and pulse to 98.

*January 22nd.*—Was very restless last night, with some delirium, but took good breakfast of light diet and says that he feels well.

*P. M.*—Was restless and somewhat excited all day. At bed time was ordered xx m of Battley's solution. This afternoon 250 grains of the iodide of potash had just been dissolved in a pint of Vichy, when the nurse's back was turned he seized the glass and drank its entire contents. No effec from this enormous single dose was evident.

*January 23rd.*—Was very delirious all night, had but little sleep. Takes food well. Temp. normal. Pulse 86. Fairly quiet all day.

*January 24th.*—Was very delirious all night. Delirium distinctly maniacal. Temp. normal, pulse 88. Takes food well, but refuses his medicine. Has now fair power in both legs. Ordered half a drachm of Battley every 4 hours by mouth.

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*P.M.*—Battley has no soporific effect; on the contrary seems to excite him. I may state that patient's mother never could take opium, as it produced great excitement. Has been very excited all day, tearing away the dressing from the abscess, also tearing bed clothes. Ordered sixty grains of bromide of potash and twenty grains of chloral, and to repeat half this dose in four hours if necessary.

*January 25th.*—At 3 this a.m. Drs. Howard, Perrigo and myself were called to his house, and found patient furiously delirious, requiring three powerful men to restrain him. The two doses of bromide and chloral had been given without effect. Gave two hypodermics of fifteen minims each of Battley. In fifteen minutes he went asleep, sleeping steadily till 10 a.m., when he awoke as delirious as ever. Had a cup of beef tea, a hypodermic of 20 minims of Battley and went to sleep again.

*January 28th.*—Since last report patient has slept fully three-fourths of the time under the influence of a hypodermic of 20 minims of Battley night and morning, waking occasionally, and very delirious. For a short time to-day seemed more rational, speaking of his illness and some business matters, but soon relapsed into delirium. Takes food well. Legs are not so well to-day—seem to have decidedly less power.

*January 29th.*—The hypodermic of Battley last night had little effect. Patient was very noisy and ugly most of the night, but takes food well; in fact, asks for it. Abscess cavity filling up well, and bed sore healing rapidly under very adverse conditions. Pulse has risen to 116, but temperature remains normal. Tongue clean and wonderfully moist considering the quantity of opium patient has taken.

*P. M.*—It was decided in consultation to try the effect of hyoscine, as patient has been very boisterous all day. At 10 p.m. gave 1-80th of a grain hypodermically. At midnight patient as boisterous as ever, gave 1-40th of a grain. At 3 a.m., there being no result, I gave 40 minims of Battley in two hypodermics. In twenty minutes patient was asleep.

*January 30th.*—Patient slept steadily till 10 a.m., when he awoke very rational; took a good breakfast. When seen at 11 a.m. was very rational.

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*P. M.*—Was very quiet all day, a little mild delirium. About 8 o'clock without warning became maniacal, requiring some considerable effort to restrain him from injuring himself and others. I was sent for, and had hardly reached his bedside when he seized his penis with his right hand and extended it to a far greater length than I thought it was possible for a human penis to be extended, at the same time exclaiming loudly, "you are the cause of all my trouble." Unfortunately, his wife heard this remark, and it gave me endless trouble afterwards. It was, however, the ground work for that subsequent investigation which enabled me to establish the specific character of the disease. Forty minims of Battley was given, producing sleep in less than half an hour, which continued till 4 a.m., when he awoke and became noisy, when 40 minims of Battley were given and he fell asleep in a short time, sleeping well till 9 a.m. Blue ointment was ordered to be rubbed into each groin night and morning.

*February 5th.*—The history of the case during the past five days has simply been a repetition of the previous eight days, with the exception that the delirium was not quite so violent. Sleep was obtained most of the time by Battley. solution, but, having again failed, hyoscine (Merck's crystals) was again tried. It did not produce sleep, but it evidently made the patient quieter. Has steadily taken the 500 grams of iodide of potash daily. The blue ointment was discontinued to-day.

*February 7th.*—Patient slept well last night under a single dose of Battley. Is decidedly better; very little delirium.

*February 8th.*—Slept well last night after a 15m dose of Battley, and is fairly rational. Battley discontinued to-night, and to have 1-25 gr. of hyoscine.

*February 9th.*—Had an excellent night, and is mentally quite himself. The last few days, in spite of his general condition, power in the legs has been gaining. To day is able to lift his left leg extended straight off the bed at least six inches and right about four inches. Can draw up both legs and place sufficient force on them, with aid of

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his hands, to lift his body off the bed. For the last three days urine was passed involuntarily, *i.e.*, he knew when he was about to make water, but could not retain it till the nurse brought a vessel. To-day he can do so. To have 1-25 of a grain of hyoscine every night. Bed sore almost well and abscess cavity contracting rapidly. The latter to be washed out with Edinburgh red wash.

*February 19th.*—Patient has made steady progress. Legs gaining in strength, can lift left leg off bed three feet, can flex and extend it twice without touching bed, and then, without any rest, hold it extended and elevated for a good minute. Can do same with right leg, except that power is not so great, and the movements are done more slowly. Has had several natural motions. Can retain his urine for several hours and give timely notice of his desire to urinate.

*February 27th.*—During past eight days patient has made wonderful progress. The bed sore has closed; has now good control over both legs and bladder. Abscess cavity, not showing any improvement of late, was to-day brushed out with solid stick of nitrate of silver. Has been taking 500 grains of iodide of potash daily since Jan. 7. To-day it was reduced to 400 grains daily. Sleeps well. Hyoscine discontinued.

*March 5th.*—Still improving; was to-day able to get out of bed without assistance, but required a little help to keep him on his feet. Continues to sleep well. Iodide of potash reduced to 250 grains daily.

*March 10th.*—Was to-day placed on sofa, and wheeled into the sun, where he remained for two hours. Abscess cavity about entirely closed. Iodide of potash reduced to 150 grains.

*March 15th.*—To-day is able to move about room with slight assistance from a pair of crutches. Began the use of the Faradic current. Legs hypersensative to a mild current, which causes some pain in legs.

*March 20th.*—Faradic current stopped, as patient is now able to move about room fairly well with the aid of a stick. To-day received a letter from Dr. Seguin, of which

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the following is an extract: "I am delighted to hear such good news of our case; it now looks as if there would be complete recovery, which is rare, as you know. What would you think of giving him alternate courses of mercury and iodide—say 1-30 grains of bi-chloride, three times a day for two weeks; then 75 to 100 grains of iodide of potash three times a day for two weeks. That is the way I usually manage the convalescent of my cases of cerebral and spinal syphilis. I have treated several cases with the large doses, such as our patient has been taking, and with marked success, and have never had in any case gastric irritability, acne or coryza. My case of cerebral sarcoma, operated on by Weir, went home to-day well, except a slight degree of right side paresis (much less than before operation). The wound was completely healed by the fourth day. Now for a spinal tumor."

Patient was accordingly placed on the treatment suggested by Dr. Seguin, giving the full dose of iodide of potash 100 gr. three times a day.

*March 25th.*—With a little assistance patient was to-day able to walk down the stairs to the first flat, and then 12 steps into the street, enter a sleigh and go for a drive.

From this date the improvement was steady, and by the 15th of April patient was able to go for a short walk without any assistance. Mercury and iodide still continued.

*May 1st.*—Patient is practically well, and thinks of soon returning to his work. Treatment still continued.

*May 15th.*—Patient went down to his office for the first time.

*June 1st.*—The iodide of potash was to-day reduced to 50 grains.

*July 1st.*—The iodide to-day reduced to 25 grains. There never has been any sign of ptyalism. Patient resumed his full work on the 15th of June.

*August 1st.*—Iodide reduced to 15 grains.

*September 1st.*—Iodide discontinued and the mercury continued night and morning. This was continued for several months, stopping now and again for a few days. Patient is alive to-day and has never had an hour's illness

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since. Connection with his wife was forbidden for two years, and I believe was faithfully carried out. About 3 years from date of illness I confined his wife of a fine healthy male child, now alive.

This case is especially interesting on account of the enormous doses of iodide of potash which the patient took. At the time I was treating this case, my son, Dr. Rollo Campbell, was clinical clerk to Dr. Stephen McKenzie at the London Hospital, and had under his care a similar one. He mentioned my case and the dose of iodide of potash I was giving, to which Dr. McKenzie replied that it was impossible for the system to assimilate such enormous doses. I told this to Dr. Seguin, who said he did not care whether the system assimilated them or not, they cured the patient. This is the theoretical and practical sides of the question. An interesting point also was the delirium, which greatly complicated matters, and greatly alarmed the friends. During the progress of the case I was in constant communication with Dr. Seguin, and his opinion was, that it was either septicemic or embolic. Concerning it he advised me as follows: "I took the liberty of telegraphing you to try hyoscine again, your dose having been too small for an active delirium. In the active delirium of general paralysis I give from the 1-33 to the 1-25 of Merck's crystalized hyoscine with wonderful effect."

So far as I can ascertain, no one has before or since in Canada taken such enormous doses of iodide of potash. The result in this case certainly justified them, and, if a similar case should present itself to me, I would not hesitate to adopt similar treatment.

1006 Sherbrooke St., Montreal, Sept., 1900.

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# PROCEDURE IN POST-MORTEM MEDICAL LEGAL EXAMINATION.

CHARLES A. HEBBERT, M.R.C.P., London,
Lecturer on Anatomy, Bishop's College, Montreal.

## CASE 5.

The body is that of a male aged fifty-three, stoutly built and muscular, height 5 ft. 8 in., dark hair, bald over vertex, on which was a small wen half an inch in diameter, moustache and beard brown, face and head much swollen and discolored, lips black, protruding and greatly swollen, tongue clenched between the teeth, some sand and mud on the face and beard, a small quantity of grumous fluid escaped from the mouth on moving the body, rigor mortis present in wrists and lower extremities, skin of surface of the body detached or detachable over arms, legs and abdomen. The thighs showed fair skin somewhat suggestive of cutis anserina, bullæ were noticed over lower part of back and abdomen, skin of hands white, corrugated and partly separable, nails undetached, decomposition most advanced over upper part of head, neck, chest and shoulders, with emphysema of the subcutaneous tissues, lower part of abdomen green discoloration, superficial veins of trunk and outer side of thighs mapped out by purplish discoloration, no signs of ecchymoses (verified by superficial and deep sections) hands half clenched, no carpopedal contractions, no sand or foreign substance under nails or in the hands, penis retracted, left side of body and scrotum much distended by gas.

Trunk and limbs protected by clothing, head and hands bare.

HEAD.—Scalp removed, no ecchymoses or injuries noticed, no fracture of skull, meninges nothing noticeable, brain, substance greyish color, soft and decomposing, no apparent congestion of vessels, no sign of previous hemorrhage, medulla and pons in fair state of preservation, and apparently normal, no fracture or injury of neck.

THORAX.—On opening thorax the viscera were found in a normal position, the pericardium being uncovered and the lungs not unduly prominent.

HEART.—The pericardium contained about an ounce of

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blood stained fluid; all the cavities of the heart contained a small quantity of black fluid blood, the walls were flaccid and dilated, muscular tissue fairly good color and firm, endocardium dark red color, valves normal, no atheroma of the aorta, coronary arteries showed a slight atheromatous condition, but the openings were patent. Lungs, no adhesions, about half a pint of blood stained fluid in each cavity, mucous membrane of trachea, larnyx and bronchi was dark red, soft, and showed commencing decomposition; no froth or fluid in the tubes; lungs were of a universal dark color, almost black, and on section some dark bloody fluid exuded, no froth in the main divisions of bronchi, though a little could be pressed out of the smallest tubes.

STOMACH.—Contained from five to six ounces of food, consisting of mutton, green peas and potatoes; the peas were mostly intact and the mutton had hardly been exposed to the digestive process; a very small amount of food was in the stomach. There was no perceptible odor beyond that usually found. Walls of intestine normal, small amount of semi-fluid fæces in both small and large intestine; bladder contained about three ounces of clear urine; walls were normal. Kidneys, right capsule adherent, cortex diminished, surface granular, color dark red; left, similar condition though less marked; adrenals normal; liver congested, but otherwise apparently normal; spleen enlarged and congested.

COMMENTS.

It is well known to medical jurists that often a difficulty arises in determining the exact cause of death in cases of supposed drowning.

The first assumption when a body is found in the water is that the individual has come to its death by drowning, especially when there are no external marks of violence, but in the careful investigation of the cause of death it must be recognized that there is no one sign, which is always present, and every case has to be decided on its merits, that is, on the whole picture suggested by the details.

The first question is, did the body enter the water alive?

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In cases of commencing putrefaction, many of the signs are lost, such as pallor of the surface, mottling and reddish patches, etc., but there may be still evidences present of cutis anserina on the extensor aspect of the thighs and arms and retraction of the penis, and these two signs were sufficiently recognizable in this case to decide in the affirmative.

The next question was death due to drowning. Death is the complete cessation of the functions of the brain, heart and lungs, the so-called tripod of life. It must ensue primarily by: 1. Asphyxia, total interference with respiration; 2. Syncope, or failure of the heart's action; or 3. Shock to the nervous system, the neuroparalysis of Casper. Any one of these conditions may be found in the bodies of the drowned, the most frequent being asphyxia, This is caused by the mechanical interference by the water of the proper entrance of air into the lungs and the consequent non-aeration of the blood. The signs in such a case are, first, a great congestion and increased volume of the lungs; this increase of volume is sometimes so great as to quite overlap the heart area and even bulge outwards on opening the chest cavity, and this sign is said by Casper, and his statement is in accordance with my own experience, to persist even in cases of advanced decomposition of the internal organs; secondly, engorgement of the right side of the heart, with fulness of the whole venous system, the blood being a dark red or black color. There is also much frothy and reddish mucus, on the lips, in the mouth, larynx, trachea and bronchi down to the smaller divisions caused by the efforts to breathe during partial or total submersion. It has been noticed in bodies which sunk at once to the bottom, though to a lesser extent. There is also redness of the membrane of the air passages. These signs are more evident in cases of robust men making a supreme effort for life, and even a suicide, however determined, must at the time of losing consciousness instinctively struggle to breathe. If a person be submerged while unconscious the signs would be similar to those sinking at once, and evidence of asphyxiation, though present to some extent, would not be pronounced.

In the next series of death by drowning, the walls of the heart are flaccid and contain about an equal quantity of

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blood in each side. There is little or no increase of volume of the lungs and no marked congestion of the nervous system.

In the third series, the brain is frequently much congested, but the heart and lungs show nothing special.

I have narrated the above case as illustrative of some of the difficulties encountered by the medical jurist, in cases of bodies found in the water and presumably drowned.

The indication was that the death was due to drowning, as the lungs were congested though not increased in volume, nor showing any frothy mucus in the air passages. This latter would probably be absent in the upper passages, on account of the length of time in the water (3-4 days), but one would have expected to see more evidence in the smaller divisions of the bronchi or section of the lungs. The heart, too, showed flaccid walls with a small amount of blood in the cavities, and were not engorged on the right side.

The most reasonable theory is that a man so strong and muscular and so capable of making an effort for life, if conscious of his danger, must have been insensible at the time of submersion. I think the above facts justify me in disposing of either accident or suicide, as, in either case, I believe there would have been more distinct evidence of drowning by asphyxiation, and in believing that the presumption was that of the homicide of a man previously rendered unconscious.

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## ABSTRACT OF PAPER ON THE OPERATIVE TREATMENT OF COMPLETE PROLAPSE OF THE UTERUS IN ELDERLY WOMEN.*

By LAPTHORN SMITH, B.A. M.D., M.R.C.S., Eng.

Surgeon-in-Chief of the Samaritan Hospital for Women, Montreal ; Clinical Professor of Gynecology, Bishops College, Montreal.

The author comes to the following conclusions :

1st. That a woman suffering from procidentia or prolapse of the uterus out of the body, though not in much pain, is yet very miserable.

2nd. She is in some danger, owing to the cervix becom-

* Read before the Canadian Medical Association, Sept. 14,1900, at Ottawa, Ont

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ing ulcerated and the ulceration frequently becoming cancerous.

3rd. It is a mistake to think that she is too old to undergo an operation because she is forty-five or fifty or even seventy-five years of age.

4th. Elderly women support these operations remarkably well; they only require from twenty to thirty minutes for their performance; and, even if we knew that the patients were only going to live one year afterwards, it would be well worth while operating for the sake of the comfort it affords them.

5th. The operation of vaginal hysterectomy is especially easy and safe in these cases, having not more than one per cent. of mortality, and probably not even that.

6th. Ventrofixation gives good results when the uterus is short, but fails when it is long. In some cases the vagina and bladder pull down and elongate the cervix, after the fundus has been firmly attached to the abdominal wall.

7th. In either case, whether hysterectomy or ventrofixation be employed, it should always be followed by an anterior and posterior colporrhaphy.

8th. These patients should remain in bed for six weeks after their operation, in order to give time for the new tissue to become strong.

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# Selected Articles.

## A RELIABLE AND HARMLESS WAY TO DIMINISH AND CURE OVER-FATNESS.

By WILLIAM T. CATHELL, A.M., M.D., of Baltimore.

[*Read at the Ninety-Ninth Annual Meeting of The Medical and Chirurgical Faculty of the State of Maryland.*]

MR. CHAIRMAN AND GENTLEMEN:

Before all else, I shall state that I have neither medicine to sell, secret to extol, nor scheme to make money out of the public, as "Eureka" titles like this are apt to suggest, but,

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agreeing that every addition to true knowledge is an addition to human power, I intend to lay before you to-day the results of nearly five years' observation upon a reliable and harmless way to remove over-fatness and the evils it creates.

That you may have a clearer conception of what is to follow, I shall first remind you that, by the natural law of proportion, fat should constitute about the one-fifteenth or one-twentieth of one's weight, and that a person's heft may vary ten or fifteen pounds either way, from the standard of weight to height, without its being significant of either discomfort or disease; also, that a certain quantity of fat is a blessing, at it not only improves personal appearance, but is necessary to protect the various organs and to maintain their temperature; and also to serve as nutrition in time of need. For these purposes it is stored in cells in various parts of the body, but more plentifully in some regions than in others.

If any one has a much less proportion than one-twentieth, leanness, lankiness or emaciation is observable; a very much greater proportion than say one-ninth or one-sixth constitutes corpulence, obesity or over-fatness, and although stoutness, to a moderate degree, is considered an element of good health and indicative of the successful working of one's physiology, yet, fatness alone is a very poor criterion of health, but, on the contrary, it is an element that possesses the power for serious mischief, because a very great amount of fat necessarily creates heaviness, impedes respiration, circulation, locomotion, digestion and other vital functions to such a degree that the person who carries such a load of bulky ballast is more burdened than blessed.

In very fat persons all the cellulo-adipose structures are filled to distension, more noticeable about the subcutaneous tissues, the breast and the abdominal walls; also in the omentum and mesentery, on the surface of the heart and about the kidneys, and, if this morbid accumulation grows to be excessive, these all become buried in fat, which mechanically interferes with both function and nutrition.

According to my observations, there are four common causes of over-fatness:

*Congenitally small lungs* with defective oxygenating capacity.

*Eating excessively of all kinds of food.*

*Want of lung-expanding exercise.*

*Alcoholics to excess.*

There are numerous well-known agents that more or less effectually reduce surplus fat, and also counteract its return. Among these, Iodine, Bromine, Mercury, Lead, Arsenic,

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Liquor Potassium, Lemon Juice, Sour Wines, Vinegar, purgatives, sweating, semi-starving, baths of various kinds, smoking and chewing, fish diet, Bladder Wrack, Phytolacca, Gulf Weed, and various quack nostrums, each have more or less reputation for diminishing weight.

Some of these, when taken sparingly or for a brief while, have a proper place and a useful power, but, unfortunately, when used in quantities sufficiently strong, and long enough continued, to destroy any considerable amount of fatty tissue, they likewise injure other structures; therefore, are necessarily dangerous to health. Besides, they all act either by saponifying the fat or by producing numerical cell-atrophy, either of which exerts powerful influence on the lympathic and absorbent systems, not only cause re-absorption and destruction of olein, stearin, margarin, protoplasm, nuclei and other physiological constituents of the fat-cells, but go further, and annihilate myriads of cell-membranes, red blood globules, and other normal and essential elements of the economy; and as these perish, all histologists know, vitality is reduced and health is impaired.

It is also well known that, while affecting the fat, many of these articles also act as slow poisons, and damage or ruin the alimentary mucous membranes and the functions of digestion, and thus cause mal-assimilation and mal nutrition, with repugnance to food. These, therefore, are all doubly injurious; and, if used too heroically, or continued beyond a certain period, anemia, general debility, marasmus, consumption or other fatal affections may be induced.

None but an idiot, however fat, wishes to endanger his health by unwise efforts to reduce it, and many overweighted persons, anxious to throw off their fleshy burden, and aware of the danger of using anti-fat drugs, determinately avoid them, and resort to pedestrianism, bicycling, gymnastics, rowing, massage, electricity, restricted sleep, thyroid extract, skimmed milk and other popular means; while a few begin a regular dietary system: Banting's, Ortel's, Ebstein's, Bruen's, or others, which all aim to limit the supply of elements that form fat, and to increase its reabsorption; and I am glad to say, to the honor of their founders, that every dietary system with which I am acquainted seems to be based on rational principles.

But ball-and-chain rules and iron-clad regulations requiring daily discomfort, long suffering, semi-starvation, abstemious dieting, etc., no difference by whom recommended, are rarely persevered with to a successful degree by persons with simple over-fatness, and we rarely meet anyone wreathed

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in fat who has not begun on one or another, or several different plans, and after awhile become either careless or disgusted, and—quit.

Neither with cases of enormous obesity, nor with celebrities of fabulous proportions, nor with over-fat invalids or semi invalids have I had any special experience, but if any healthy person, whether male or female, weighing less than 300 pounds, with *simple, uncomplicated over-fatness*, wishing to make a fair, honest and faithful trial of my plan to diminish over-fatness, will begin and drink a large glass of Kissingen Water twenty or thirty minutes after each of the three daily meals one day, and a similar glass of Vichy Water after each of the three daily meals the next day, and persistently continue to take them thus, week after week, he will begin and gradually lose fat, until he comes down to medium weight and stoutness, and be correspondingly relieved of the discomforts and the dangers of obesity; after which their use should be discontinued.

The natural Kissingen and Vichy waters, when fresh, answer our purpose equally well, but I have learned to prefer the artificial compound made by the chemist's ingenuity to imitate the natural waters when the springs (Rakoczy and Grande Grille) are at their best, because, to be successful, both waters should be used while still fresh, and, as the natural waters are brought from afar by the cargo and carload, there is danger of their becoming so stale and altered before use as to be wholly unreliable, and in actual practice I have found the artificial waters, made from the Kissingen and Vichy powders to be equally or even more definite in quality than the natural waters, therefore more certain in their action on fat.

Kissingen and Vichy Salts, taken in ordinary water, are said to reduce fatness, but in a lesser degree, owing probably to the absence of carbonic and other gases; with them, given this way, I have no experience.*

It is useless to take either Kissingen or Vichy alone, as they act only when both are taken, and taken alternately. The temperature at which they are used is immaterial.

While using the Kissingen and Vichy, the person should, as a necessary guide, keep tally on his girth and weight; by taking his measures, and by carefully weighing his body, in the same clothes, and on the same accurate scales, every two or three weeks, and if he has lost more

* Since the above paragraph was written, I have been furnished with abundant proof that Kissingen and Vichy Salts, both plain and effervescing, do act efficiently.

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than a couple of pounds for each week, take a smaller glass of each at every drink, and if he has lost less than a couple of pounds for each week, *squeeze a few teaspoonfuls of lemon juice into each glass of the Kissengen, to increase its acidity, and also add one teaspoonful of the Aromatic Spirits of Ammonia to each glass of the Vichy*, to increase its alkalinity. He can further aid them by using acidulous food and drinks on the Kissingen days, avoiding them with the Vichy.

He should also lend assistance to the action of the waters, not by a too restricted diet, which is not good even for the obese, but by using starches, sugars, fats, alcoholics and all other fat-forming food, but sparingly; avoid overeating, and use neither food nor alcoholics except at the regular meals; also take early and light suppers, so that from that time until breakfast, the longest of the three intervals between meals, there may be but little pabulum for fattening, and favorable conditions for reduction; and especially that there may be complete emptiness of the stomach during sleep, so that nature may then utilize some of his surplus fat as fuel for the ceaseless wear and tear. He should also take moderate out-door exercise, on foot or wheel, or in any other way that will increase and deepen his respiration and promote tissue oxidation.

After drinking these waters and following these rules for awhile, he will find that he is losing part of his girth and a couple of pounds of avoirdupois every week; and that the loss consists entirely of useless fat; and that his appearance, activity and feelings will all be improved—just as if there exists some natural antagonism between these waters, taken thus, and adipose tissue; more especially that located in the great fat-centres already mentioned.

Now, while it is extremely difficult to search out the ultimate of anything in physiology—for instance, why opium relieves pain, and colchicum benefits gout—yet, after studying this subject thoughtfully, I am quite sure there exists either a specific physiological action or some definite chemical affinity between Kissigen and Vichy, taken by this rule, and abnormally fat human tissues, that results in a lessening of the fat, with neither purging nor sweating, or injury to brain, blood, muscle or general health; but how, or why, I cannot yet explain.

They may reduce adipose and prevent further infiltration or storage, in either of several ways: One is, by merely inhibiting or controlling the disproportionate activity of fat-cell nutrition; thus placing less fatty pabulum and more blood, brain, muscle, nerve and gland elements, at the dis-

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posal of the absorbents, while the fatty tissue and oily material of the body, being the most lowly organized, are naturally the first to be removed by the corrected physiological processes.

Or, we may find that they act as alteratives, and restore equilibrium to the nutritive processes, by destroying or neutralizing some morbic fat-forming agency, occult derangement of digestion, or perversion of assimilation, that have been causing diminished oxidation, and a consequent accumulation of fat.

Again, when we study their analysis, and consider the complexness of the potent medicinal ingredients that lie hidden in each glass of these waters, another rational hypothesis arises: Kissingen being an acidulous *saline*, and *Vichy* an *alkaline*, and both containing salts of calcium, magnesium, potassium, sodium and other minerals, in decided and definite quantities, united with carbonic acid and other gases, it seems logical to suppose, that when *alternately* mingled with the food-pulp or chyme in the stomach and intestines, day after day, their special combination of ingredien s brings about reduction by some chemico-physiological readjustment of the alkalinity and acidity of the blood and the visceral fluids, or possibly of both humors and solids; and that this readjustment makes the fat-yielding pabulum less plentiful and less favorable for fat-creation, and metabolically explains why increase of fatness ceases, and why reabsorption of the surplus contents of the fat-cells begins, and also why this physiological reduction and reconstruction results, all uniting to prove that Kissingen and Vichy, taken by this plan, are a reliable combination for preventing increase and reducing surplus fat to the normal proportion of one to fifteen or twenty.

But, whatever their exact mode of action may be, there certainly exists some natural and well-marked antagonism between these two waters taken thus, and adipose material, that tends to restore normal balance between the quantity of it and of other tissues. This has been proven again and again. In some cases, however, the direct and immediate effect of Kissingen and Vichy is more perceptible than in others, because some types of fatness reduce more easily and more rapidly than others. The more firm and solid the flesh, and the longer one had been fat, the more slowly it yields. Such a one, if quite fat and belonging to a constitutionally fat family, with proportionately small lungs, might require a persistence with Kissingen and Vichy methodically for six months or even longer, unless the ammonia and lemon juice

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are added regularly. Ungovernable appetite, failure to exercise, tippling, etc., may also retard or prevent success.

In some of these "stubborn" cases, a considerable decrease of size with but little lessening of weight has been observed.

In addition, Kissingen and Vichy not only reduces over-fatness, but also tend to permanently correct the irregular and excessive fat-making activity on which it depends without injury to health. The person gradually becomes thinner, looks healthier and feels younger and more active, as his (or her) superabundance disappears. At the same time, the skin, being an elastic and active tissue, contracts correspondingly, leaving neither flabbiness nor wrinkles, bagginess nor crow's feet, while brain, muscle, nerve, blood and glandular nutrition and strength all remain normal, proving that this method does not cause either pathological diminution or morbid shriveling from inanition or loss of strength, or constipation with cachexy, from impaired digestion, as the various "anti fat" blood depuratives and glandular eliminatives are notoriously apt to do.

To properly appreciate this fact, it must be remembered that a person in normal flesh has as much blood, and usually better blood, than a similar person whose weight has been ever so much increased by fat, and that Kissingen and Vichy act on the fat and not on either the blood, the glands or the bowels.

My atttention was first called to the peculiar power of this combination over fat fully five years ago, in this way: Mr. McK——, a hearty looking, middle-aged gentleman, who was consulting me for an unimportant affection of the throat, informed me that, in addition to this, he had lost about thirty pounds of flesh within the last half year, without sickness, loss of appetite or any other apparent reason, and that he was mystified and unable to discover the cause.

On inquiry I gleaned nothing important, except that for several months he had been following the habit of drinking artificial Kissingen and Vichy waters daily, under the belief that, being called for so often by soda water patrons, they must be good for one's health.

His throat being better, he soon passed from my care, with his loss-of-weight mystery unsolved.

The following year, Mr. J. H. H——, a young man of thin visage and notable leanness in general, asked me the cause of his losing nearly nine pounds in weight. Among other things, I learned that for a year or more he and a companion had been daily visitors to a near-by soda water

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fountain, and tiring of the various syrups, they had changed, five or six months before, to Kissingen and Vichy, and that shortly thereafter they both noticed that they were getting thinner and thinner.

Remembering Mr. McK——'s decrease, and putting this case and that together, I told him of the resemblance, and caused him to discontinue Kissingen and Vichy immediately. Emaciation shortly ceased, and under tissue-building tonics he gradually regained what had been abstracted from his scanty stock of fat.

Feeling quite sure that I now had a clue to the mystery, I sought out Mr. McK—— to tell him, but suspecting the waters himself, he had long since quit them, and his loss of weight ceased, making him quite sure as to the cause.

A few months after this, friend McK—— called at my office with a young Canadian, Mr. W. D. W——, a bartender, whom he had incidentally met, and wished me also to see him. His weight, under the liberal use of Kissingen and Vichy, had fallen, during the past summer and fall, from 223 to 180 pounds. He explained to me that, being a bartender, he was kept in constant contact with liquor drinking, and, being pledged against all intoxicants, yet, not wishing to offend customers, he would take a dozen or more small shell glasses of either Kissingen or Vichy daily, drinking whichever they had most of in stock.

He further informed me that his decrease in weight, and a striking rejuvenescence in his appearance, activity and feelings, began shortly after commencing this habit. His lessening in weight had also ceased promptly after Mr. McK——had caused him to quit them.

This was more than three years ago. His size still remains at comfortable stoutness, and his weight keeps below 200 pounds.

Anxious to utilize this discovery, and determined to neglect nothing in pursuit of the truth, Kissingen and Vichy have since been experimented with by me, and by others, on different fat-laden persons at various hours and in varying quantities, and, as the result, I would recommend their use in the quantities and at the hours already mentioned, since these, in my opinion, constitute the most effective time and quantity.

At a recent interview Mr. W. D. W——, the bartender, told me that constantly fearing his superabundant fat may again force him above ordinary stoutness, he has adopted the habit of drinking a few glasses of Kissingen and Vichy daily, for ten or fifteen days, several times a year.

Governed by this and other cases, I would advise those

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with the smaller degree of over-fatness, who wish to effect a slight and gradual reduction of size; and also, those merely seeking to reduce unsightly chin, facial, bust, hip or abdominal fat, or to keep their general bulk down to the natural to drink Kissingen and Vichy now and then, instead of adhering rigidly to the regular system.

When the excess is chiefly below the waist, causing what is called "large stomach," wearing a snug abdominal supporter or a moderately tight abdominal binder, while pursuing the method, makes the fat disappear much more promptly from this locality, and also braces up the reduced form as absorption progresses.

My father, Dr. D. W. Cathell, has recently, at my request, tested this method on nearly a dozen cases of over-fatness with favorable results, and I hold in my hand now the records of eleven cases, seven males and four females, who have used Kissingen and Vichy, more or less methodically, with the following positive results: A fat grocer, reduced from 310½ to 289 pounds in eleven weeks; barkeeper, reduced from 223 to 180 pounds in nineteen weeks; a lawyer, reduced from 191 to 173 pounds in fourteen weeks; young real estate agent, from 173 to 151 pounds in twelve weeks; clergyman reduced 16 pounds in nine weeks; lady, aged 28 years, from 286½ pounds in thirteen weeks; stout actress, from 173 to 166 pounds in seven weeks; young English lady, from 149 to 142 pounds in five weeks; conductor on steam cars, from 183 to 174 in six weeks; lady, aged 41, from 173½ to 160½ pounds in eleven weeks, and that of a well-known physician, who was reduced by an irregular use of Kissingen and Vichy from 211 to 196½ pounds in nine weeks.

Fortified by such observations, I do not hesitate to assert, that the *heavy laden*, who are suffering with the fat-forming diathesis, and wish to reduce their surplus to healthy limits, and to regulate its further formation do so by avoiding over-eating, limiting the use of sugary and starchy articles, fatty and oily food and the alcoholics, and using Kissingen and Vichy Waters by the rules already mentioned.

Based on equally clear proof, I am also equally convinced that the lean, the puny, the slim, the pale and the flabby; those with weak hearts, irregular circulation, poor vitality or limited health; together with all that numerous class of *feather-weights*, whose percentage of fatty tissue is so scanty that they should either try to increase the number and fulness of their fat-cells, else let them remain as they are,

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should seek good, nutritions food, fresh air and moderate exercise, and avoid mineral waters in general, and Kissingen and Vichy in particular.

My sole object, Mr. Chairman, in bringing before you a subject so far separated as this from the specialty to which I limit my practice—the Nose and Throat—is, that having observed what I believe to be a valuable therapeutic fact, I feel it to be my duty to lay it before the profession.

1308 N. Charles Street,

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## THE TREATMENT OF DIARRHŒA.

By JOHN V. SHOEMAKER, M. D., LL. D.,
Professor of Materia Medica and Therapeutics in the Medico-Chirurgical College of Philadelphia.

The residue of incompletely digested food acts as a foreign body and irritant to the mucous membrane of the bowel, augmenting the secretion of the follicles and exciting peristaltic movements. These represent nature's efforts to remove offending material. They are in so far conservative that, after expulsion of the irritating mass, its pathological consequences, and the symptoms to which they give rise, tend to subside.

Fermentative changes, especially in amylaceous articles of food, cause pain and aggravate the mischief. Indigestion is the starting-point of ordinary cases of diarrhœa. Prominent causes of indigestion are irregular and hurried meals, active bodily or mental exertion directly after substantial meals, nervous agitation or depression, insufficient mastication, and the influence of summer-heat. With the exception of the last named factor, they are operative every day all the year round. High temperature favors the occurrence of indigestion and diarrhœa by its powerfully depressant action on the nervous system. Indiscretions which would produce little result in colder weather may provoke a severe attack of diarrhœa in summer. Beyond doubt the rapid and frequent drinking of ice-water assists in the development of intestinal disorder. It goes without saying that all these morbific elements act particularly upon infants and young children, and summer is pre-eminently the season of infantile diarrhœa. Furthermore, along with diminution of digestive power, the milk supplied by dealers may have itself undergone changes which render it a direct cause of disease. The fermentation of the intestinal contents is due to the activity of bacteria, which abound in the canal.

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These brief considerations already furnish us with some guiding points relative to the prevention of diarrhœa. The first thought which suggests itself relates to the importance of careful hygienic and dietetic habits. The active and persistent efforts of the medical profession have brought about a great and beneficial improvement in the nature of our milksupply. It is now generally possible for citizens to obtain a pure, unadulterated, and sterilized milk. The artificial rearing of infants has received close study within the same period, and conspicuous advances have been made in our methods. Together with these alterations, it has become much more customary for people to make holiday excursions to the country or sea-side. It is now within the means of most persons to take such summer trips. A sojourn of only a few days in the purer air of the country accomplishes great good, both as a prophylactic and remedial agency. A ride to the park on open trolley-cars or a trip on a river steamboat are other short outings which can be taken at a moment's notice and which soon transport ailing children and wearied mothers to more favorable surroundings. For such reasons, alluded to thus cursorily, and others which act in a similar direction, severe cases of infantile diarrhœa and cholera infantum are, I think, considerably less numerous, in Philadelphia at least, than during the earlier years of my practice in this city.

Scrupulous cleanliness of the integument and attention to the gastro-intestinal mucous membrane are of much avail in the prophylaxis of diarrhœa. The utility of bathing or sponging the body with cool water is unquestionable. The direct abstraction of heat quiets the nervous centres and invigorates resistance to deleterious influences.

Our patients, however, generally come to us when disease is already established. The time for prophylaxis is past. A regulated diet has much remedial influence. If an acute case is seen early, and, above all, if particles of undigested food are passed with the discharges from the bowel, I adhere to the old, but sound, parctice of giving a dose of castor-oil and laudanum. A laxative dose of the oil is ordered together with five or ten drops of laudanum or a proportional fraction in case of young children. This combination sweeps away offending material, reduces turgescence of the intestinal mucous membrane, and assists in checking the discharges. In severe cases it paves the way for the administration of other agents.

In infantile diarrhœa, and more especially in the graver forms, or cholera infantum, it is necessary to restrict the

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diet. It is at all times too much the custom for parents to allow young children to "have the run of the table," as they express it, or, in other words, to partake of the same food as their elders. In numberless instances this pernicious practice is the foundation of indigestion and diarrhœa. Those of tender years should be fed upon simple, nutritious and easily digestible food in accordance with the physiological laws of digestion. In such cases I forbid the use of bread, meat and potatoes. If a babe is at the breast, it is, of course, getting the sustenance which nature designs for it, provided that the mother's milk is of normal quality and sufficiently abundant. In artificially reared infants I restrict the little patient to sterilized cows' milk, modified as regards the water and sugar according to the age of the child, to barley-water, rice-water, or rice-water and milk; the white of egg whipped up with milk and slightly sweetened; to junket, or the expressed juice of meat. A good variety of artificial food also often answers a useful purpose in this class of cases.

In the medicinal treatment of diarrhœa the combination of an opiate and astringent was long the accepted method. To a large extent this plan has been abandoned with our altered conceptions of the pathogenesis of inflammation. It is now generally regarded as a more rational procedure to disinfect the alimentary canal, to check the development of bacteria, and neutralize their deleterious products.

Ipecacuanha is a drug which I often employ in small doses, particularly in the diarrhœa of infants and young children. Used in this way it possesses a stimulating influence on the functions of stomach and liver, acts upon the intestinal glands, and strengthens the digestive functions. It should be remembered that the digestive fluids themselves are inimical to the growth of bacteria. Bismuth has a valuable sedative action upon the intestinal mucous membrane, and is of decided service in diarrhœa. Its influence is directly local, and to a certain extent mechanical. On account of its comparative freedom from toxicity it can be given to young subjects in appreciable doses. The subnitrate is the salt most frequently employed, although the subcarbonate is also an excellent preparation. The salicylate of bismuth is likewise serviceable in summer diarrhœa, and is more decidedly antiseptic than the subnitrate or subcarbonate. One or other of these salts may be effectively given in conjunction with ipecacuanha. In cases accompanied with much pain the last drug may be advantageously prescribed in the form of Dover's powder. Some of the preparations of calcium are also of benefit, especially when the feculent discharges are unusually acrid.

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Liquor calcis, creta preparata, the carbonate, phosphate, or salicylate of calcium may be beneficially added to some such combinations as have just been indicated. Salol is an efficient disinfectant of the intestinal tract and is of undoubted value in diarrhœa. By reason of the proportion of carbolic acid which it contains and the consequent possibility of damaging the kidneys the urine should be watched while a patient is taking salol. I customarily order it in the dose of five or ten grains for the adult, and in amounts graduated tothe age of young children. Salicin is an analogous remedy which I often employ. It is well tolerated by the stomach, is tonic and antiseptic. It can be given in doses of one grain to children one year of age. Naphthalin and naphthol, both the alphanaphthol and betanaphthol varieties, also antagonize diarrhœa in a similar manner to the salicylates. I have myself generally given the preference to betanaphthol. This preparation is of rather exceptional antiseptic power, though comparatively innocuous.

Camphor is a valuable remedy in diarrhœa. It checks the growth of germs, dispels flatulence, arrests discharges, and combats the debility which has been caused by excessive drain. Carbolic acid or creasote may likewise be employed with advantage. They act by disinfecting the intestinal canal and by arresting fermentation. Another agent which possesses a distinctively favorable influence in most forms of diarrhœa is coto-bark. This remedy has proved of value in functional diarrhœa, cholera infantum, and gastro-intestinal catarrh, but is contra-indicated where there is decided hyperæmia or ulceration of the bowel. A number of mineral and vegetable astringents have been employed from time immemorial. Many of these are endowed with antiseptic properties, and are, perhaps, as efficient for this reason as on account of their astringency.

Chloral is an efficacious drug, particularly where the lower bowel is affected and tenesmus is present. In this substance likewise we have an excellent antiseptic. Chloral reduces the excessive peristalsis which is one of the factors in diarrhœa. I have generally used this remedy in the form of a suppository, and in the class of cases which I have indicated it is undoubtedly of decided value. It is often well to associate a little opium with the chloral. In severe cases an efficient method is the irrigation of the bowel with large quantities of plain or medicated water. This procedure is capable of producing an antiperistaltic movement whereby the fluid passes through the ileo-cæcal valve and obtains admission to the small intestine. In this manner we are able to exert a

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powerful and direct impression upon the inflamed gut. For an adult the quantity of water used is four pints, in which is incorporated from two to four drachms of tannic acid, one and one-half ounces of pulverized gum arabic, and thirty drops of the wine of opium. For children the amounts must be proportionately reduced.

There are many more substances which I might enumerate and which have been used with more or less success, but the foregoing outline-sketch includes those upon which I have been accustomed to rely. They are synergistic, and may be often variously combined with much benefit.—*The Medical Bulletin.*

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# Progress of Medical Science.

## MEDICINE AND NEUROLOGY.

IN CHARGE OF

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### UROTROPIN AS A URINARY ANTISEPTIC.

At a recent meeting of the Leeds and West Riding Medico-Chirurgical Society, Cammidge (British Medical Journal, March 17, p. 641), after briefly referring to a case of cystitis complicating enteric fever in which urotropin had proved beneficial, gave details of investigations that he had carried out with regard to the action of urotropin on the urine from patients who had taken it, on the bacillus typhosus, the bacillus coli communis, and the staphylococcus pyogenes aureus under various conditions. He also described some chemical experiments designed to determine the mode of excretion of the drug in the urine, and the cause of its marked antiseptic and inhibitory powers over the growth of micro-organisms possessed by such urine. The result of these experiments seemed to show that, although this action is in part probably due to the urotropin itself, excreted unchanged in the urine, another and more powerfully inhibitory substance is present. This was not thought to be free formaldehyde, but possibly a sodium compound of this substance. There is both clinical and experimental evidence tending to show that one condition necessary for success in using the drug as a urinary antiseptic is that the urine should

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be acid in reaction, as it is secreted in the kidney. Stress was laid on the marked inhibitory action of urotropin, and still more of urine containing urotropin on the typhoid bacillus, and it was pointed out that there is a wide field of usefulness for this drug, both in the treatment of cystitis and other conditions liable to complicate enteric fever, and as a preventive against the dissemination of typhoid bacilli by the urine. It was suggested that all patients suffering from enteric fever should receive ten grains three times a day from the end of the second week on, during convalescence. Reference was also made to the usefulness of the drug in the cystitis accompanying enlarged prostate and stone, as well as the benefits to be derived from its administration in the presence of bacteriuria, some cases of nocturnal enuresis in children, and as a preparation for operations on the urinary tract.—*The Journal of the American Medical Association.*

## DIET IN NEPHRITIS.

According to David, when cases of acute nephrectomy first come under treatment, it is best to enjoin rest in bed, withhold all food for twenty-four to thirty-six hours, give water freely, and cleanse the alimentary canal by purgation. Milk should then be given, first in small quantities at intervals of two hours, the amount gradually increased until two quarts are taken daily. It is best given in small amount, one or two ounces at a time, especially if there is any distress on taking it. Where the patient can not take it, either plain or flavored water-gruel may be given, but there is really no substitute. When the urine becomes copious, farinaceous foods may also be prescribed, and, when albumin disappears, egg can be tried. Close watch must be kept on the addition of albuminous foods in the diet. Red meats should not be eaten until recovery is complete. When the stomach is intolerant at the beginning, water should be given hypodermatically by the rectum, to insure renal elimination, but as a rule, when the bowels are well emptied, the kidneys begin to act and vomiting ceases. In chronic diffuse nephritis the indication for milk diet is similar, but the disease is so prolonged that it can not be maintained continuously and may be given intermittently, or sometimes modified by the addition of bread, starches, fruits, etc. Vegetables can generally be given, but rhubarb, sorrel and tomatoes should be excluded, perhaps also cabbage, asparagus, spinach and artichokes, on account of the oxalates they contain. Eggs are the least harmful of albuminous foods. The effect of

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fish is questionable, but, if fresh, it is probably as little harmful as any. Salt and smoked meats, excepting ham, should be avoided, and fried articles generally. In chronic interstitial nephritis an abstemious diet is advisable; even simple animal food should be used in small quantities, excepting milk. Tea, coffee and chocolate can be used in moderation. Water is the beverage; alcohol is forbidden.—*Jour. Am. Med. Association.*

## INTESTINAL INDIGESTION, DIET IN.*

In prescribing a special diet one principle should always be kept in mind, which is that a well-adjusted mixed diet, when it can be perfectly digested and absorbed, is the height of perfection.

In almost every instance of intestinal indigestion the mixing of the various kinds of foodstuffs will not be tolerated by the enfeebled and already-defective digestive apparatus. So long as this plan is pursued the case will not improve. In all cases of intestinal indigestion, from the mildest to the most intense type, it is absolutely necessary to limit the diet to a greater or less extent, both as regards quantity and the kind of foodstuffs taken. In many instances it may be necessary to limit the diet to a few articles of food, as milk, barley-gruel, or broths, and even these in very limited amounts, so much so that, at times, the patient may even lose flesh, while the digestive function is being slowly, but surely, re-established. The fancy of the patient must not be considered, but that form of diet must be chosen which will be most effectually digested and yield the largest amount of nutrition.

The mixed diet which most effectually meets the foregoing demands, as soon as it can be tolerated, is one composed of milk, eggs, meat and toast, or stale bread and butter. The ideal mixed diet, as personally arranged, makes very good working standard:

For breakfast.—Two eggs, 8 ounces of milk, 2 ounces of wheat-bread and butter.

For the midday meal.—From ¼ to ½ pound of beefsteak, 8 ounces of milk, 3 ounces of wheat-bread and butter.

For the night meal.—From ¼ to ½ pound of beefsteak, 8 ounces of milk, 2 ounces of bread and butter.

At bed-time.—Eight ounces of milk.

Beefsteak is taken as the working standard among the

* From the Monthly Cyclopedia of Practical Medicine, June, 1900.

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meats, as it is the most easily digested of all the foodstuffs. Under the heading of meat is included lamb, mutton, occasionally veal (the word "occasionally" refers to the frequency of use); all kinds of fish, including the shell forms, such as oysters, clams, lobsters and crabs; poultry and game of all kinds.

The meats to be broiled, boiled or baked.

The fish to be boiled or baked.

The oysters and clams to be eaten raw or stewed in their own liquor.

A little crisp bacon may be taken from time to time, also ham and corned beef, without cabbage.

Eggs may be boiled, poached or scrambled.

The milk is best taken warm or with a little lime water added.

Wheat bread is taken as the standard, because it is the most easily and perfectly digested. It should be at least twenty-four hours old or toasted; rye, graham, zwieback or the health-food breads may at times be substituted.

Weak coffee, without milk or sugar, or with a dash of milk, may be taken freely as a beverage.

Coffee taken clear aids digestion, but with milk and sugar often disturbs digestion.

To enlarge the above diet the following may be used:

In the line of vegetables: string beans, green peas, Lima beans, spinach, lettuce, asparagus and cauliflower. They should be well cooked, and only one vegetable at a meal.

When a vegetable is taken with the meal there must be a reduction in the quantity of meat or milk as given in the above table.

In case one particular form of meat cannot be tolerated, another kind must be substituted. In like manner, if milk or eggs cannot be tolerated, another kind of food must be substituted. The same rule holds true in the selection of the vegetable substances.

The following foodstuffs are excluded:

All fruits, either cooked or raw; all cereals and breakfast foods; nuts, sweets and pastry of all kinds; potatoes in all forms; onions, tomatoes, turnips, parsnips, carrots, celery, radishes, cabbage, egg and oyster plant, corn, etc.; pork in all forms, except as before stated. Rich gravies, and all forms of soups are excluded.

The medicinal treatment of intestinal indigestion and its sequences is equally as varied and important as the dietic management. W. H. Porter (*Phil. Med. Jour.*, May 26, 1900.

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## THE TREATMENT OF ACUTE INTUSSUSCEPTION.

When in a previously healthy infant we observe severe abdominal pains occuring in paroxysms, each paroxysm being attended by vomitting and more or less collapse, and when there are present tenesmus and mucous or bloody stools, we most probably have to deal with an acute intestinal intussusception. When, in addition to these symptoms, we can make out an elongated tumor on abdominal palpation, or can feel a protrusion on rectal examination, the diagnosis of this condition can be made with almost absolute certainty.

What should the general practitioner do to relieve this condition? If the symptoms are urgent, it will probably be impossible to reduce the intussusception by injections when the condition has lasted for many hours. If we try this method of treatment, the child had better be anesthetised and inverted, and hot salt solution injected into the colon under a pressure of only three or four feet. The amount the colon will hold differs very much in different cases. There is certainly some danger of rupturing the gut, even with slight hydrostatic pressure, if it be gangrenous. Whether it is gangrenous or not at the time of the injection, we can only judge by the acuteness and duration of the symptoms. The actual number of cases in which rupture of the intestine from hydrostatic pressure has occurred is very small; nevertheless, some excellent authorities state that this method should never be employed in acute cases when the disease has lasted more than twelve hours. A great objection to it is that it is apt to lead the timid into placing too much confidence in it, and so cause most valuable time to be lost. When the situation of the obstruction is in the small intestine, reduction by hydrostatic pressure need not be attempted, as water will not pass the ileo-cecal valve, except in the rare instances when it is congenitally deformed. Air is more apt to be successful in these cases, and has been particularly advised here because it is more likely to pass the valve. Dr. Rotch has pointed out that, as the invaginated portion of the intestine is not on a line with the axis of the canal, but at an angle to it, hydrostatic pressure when persisted in may tend to push the different layers of the intestine together, and so actually prevent reduction.

Intussusception must be regarded from the beginning as a surgical and not a medical affection. By some surgeons injection is only tried in very recent cases, and then only after every preparation has been made for laparotomy should

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the former method fail. Others do not attempt reduction by injection at all, but proceed at once to operate. Injection is only of value when it is easily successful, so that, like taxis in strangulated hernia, it should not be persisted in. Operation is far more likely to result favorably if done early, before adhesions have formed or gangrene occurred. Even the occasional operator is more likely to be successful early in the affection than if, beguiled by ultra-conservatism, he continue to try the injection treatment until inflammatory changes have occurred. Firm adhesions greatly increase the difficulties of the operation, while gangrene makes the prognosis almost hopeless.

Again, it is often impossible to tell with certainty whether the intussusception has been reduced when the injection method has been employed. It is highly probable that the so-called recurrence after reduction is only a recurrence of the symptoms, due to partial or complete failure to effect reduction. It would seem then that early operation is indicated both because the operation is much simpler and more likely to be successful at this time, as well as because it is the only method by which we can be absolutely certain that reduction has been accomplished. That young children stand abdominal operations badly is denied by excellent authorities, and, even if true, should not deter operation in what is nearly always a fatal affection when reduction is not accomplished easily by injection or early surgical interference.—*Pediatrics.*

## A STUDY OF LESIONS OF THE LIVER IN YOUNG CHILDREN.

Rowland Godfrey Freeman, M.D. (*Archives of Pediatrics*, 1900, xvii., p. 81), in a paper on this subject concludes as follows:

1. Descent of the liver down the right side of the abdomen, so that the right lobe reaches below the crest of the ilium, occurs not very rarely in infants, and particularly in those whose liver is enlarged.

2. Fatty liver occurs very frequently in the infants and children which die at the Foundling Hospital, or in about 41 per cent. of all cases.

3. The condition of nutrition of the child, as expressed by the absence of fat in general and wasting of tissue, apparently has no connection with the fatty condition of the liver, the condition of nutrition in the cases having fatty livers averaging about the same as in the whole number of cases.

4. Fatty liver occurs rarely in the following chronic

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wasting diseases: Marasmus, malnutrition, rachitis and syphilis, unless such condition be complicated by an acute disease.

5. With tuberculosis fatty livers occur not more often than with other conditions.

6. Fatty livers occur most often with the acute infectious diseases and gastro-intestinal disorders.

7. The two cases of cirrhosis of the liver examined by the writer ran a comparatively acute course. The livers on section showed a marked hyperplasia of the so-called new-formed bile-ducts.

8. Focal necrosis of the liver may be a lesion of measles.

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# SURGERY.

IN CHARGE OF

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## GENITO-URINARY TUBERCULOSIS.

The introduction to this lecture contains some general references to genito-urinary tuberculosis, primary and secondary. The affection may be of the "ascending" or "descending" type, and as regards relative frequency of tuberculosis in each system, Guyon found in 264 cases that the genital system was affected alone in 41, the urinary system alone in 88, and both together in 135. Tuberculosis of the urethra appears to be rare, but may occur in the upper part secondary to disease of the prostate, and to tuberculous cystitis.

The epididymis in the male seems to be the part of the genital organs most frequently affected with tuberculosis, and in adults it seems probable that in the majority of cases the disease commences in the epididymis.

The lesions in almost all cases are, or ultimately become, bilateral. Bacilli may reach the affected organ in various ways, as from the urethra (though Cheyne regards this as doubtful), from the blood, from the lymphatics or by descent along the vas, or from the peritoneum, especially in in-

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fants, where often the testicle is invaded before the epididymis. In the epididymis and testis acute tuberculosis may be part of a general acute tuberculosis, or may be a limited disease, and then usually involves the testicle first, and leads to the rapid destruction of this organ, with early extension to the epididymis. In the other local form, which is more common, the process is chronic, affects the epididymis, either invading the connective tissue outside the vas, or commencing in the interior of the duct. Beginning in globus major or minor, it spreads quickly to testis and to cord, involving later the vesiculæ seminales and prostate. The treatment of tuberculous epididymitis may be nonoperative or operative. It is certainly the case that a considerable number of cases of tuberculous epididymitis become quiescent, either without suppuration, or after suppuration has occurred, and the thickening may after a time completely disappear. This is, however, difficult to fortell in any given case, and it is to be noted that there is a tendency in all for the disease to spread to other parts of the genito-urinary system, or to the other side, even where the primary disease is improving.

Non-operative treatment is indicated in very chronic cases, or when other parts of the genito-urinary system are already affected. It consists in good hygiene, support to the testicle, and avoidance of injury. Cod liver oil, guaiacol and iodoform may be given. Operative treatment consists of scraping and epididymectomy, and of castration. In early cases epididymectomy may be classed as a radical operation. This method was first advocated by Bardenheuer, and Cheyne gives a description of the technique, and advises that the vas deferens should always be removed as high as possible. The relative merits of castration and epididymectomy are discussed at some length in this paper, and Cheyne thinks that the latter operation is well worthy of more consideration than it has yet received in this country, though it is by no means applicable to every case.

Tuberculosis of the prostate is described next, and its treatment by antiseptics and injections detailed; and it is pointed out that surgical intervention is practically limited to those cases where suppuration is occurring.

Tuberculosis of the bladder, usually secondary, may occur primarily, and is more frequent in males than in females, and attacks by preference young adults, and then most commonly in the region of the trigone. The bladder capacity is diminished and its walls thickened. Treatment may be medical or surgical, but a cure by either method is not a matter of certainty though much may be done to alleviate suffering. Operative measures consist in opening

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the bladder and draining it, in attempting to remove the tuberculous ulcerations, or in applying antiseptic substances to them. The essential point is to obtain rest for the bladder. About 80 per cent. are much relieved by the operation, and about 20 per cent. apparently cured. Tuberculosis of the kidney may be primary or secondary, and is not uncommonly unilateral in the early stage. Surgical treatment is becoming more and more frequent, and the various measures that may be adopted are :—

1. Nephrotomy and lumbar drainage to prevent infection of the urinary passages.

2. Nephrotomy combined with scraping out as much as possible of the tuberculous material.

3. Nephrectomy often associated with removal of part of the ureter.

4. Partial nephrectomy in which only the diseased portions of the kidney are taken away.

Nephrotomy in such cases must be looked on as a preliminary operation, with the view of getting rid of the fever and generally bad condition of the patient, and after a time the question of nephrectomy as a curative procedure must be considered. To justify nephrectomy one must be pretty sure that the other kidney is intact, and also that the bladder is free from disease. It is by no means easy to make certain of these points, even with the aid of a cystoscope and urethral catheter, or by means of laparotomy and palpation of the kidneys through the wound.

Of late some good results have attended partial nephrectomy.—*W. W. Cheyne, Brit. Med. Jour*; *Med. Chronicle.*

## A NEW METHOD OF STERILIZING THE HANDS AND THE FIELD OF OPERATION.

R. Kossman, of Berlin, in *Centr. fur Chir.*, November 23, 1899, proposes a method which may be described as a substitute for the rubber gloves. It is, more correctly speaking, a very thin, yet accurately fitting glove, since it is a really impervious covering applied to the hands by soaking them in a substance which quickly dries by evaporation, leaving a smooth, flexible, yet sufficiently durable, coating, as thoroughly protective as any rubber glove can be, without its disadvantages. It remains only for further experience of other surgeons to say whether the claims of the inventor shall be substantiated.

The material is a fluid holding in solution "certain hard resins and fatty oils in a mixture of easy-boiling ether and alcohol." The substance has been patented under the

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name Chirol, which name has also been protected by law. The fluid is applied to the hands by immersion after they have been first thoroughly cleansed and disinfected, and then well dried. In two to three minutes it is quite dry, and the hands are covered over with a beautifully fitting glove. It is easily removed by soaking in spirit.

We sum up the following advantages of the plan:

It has all the advantages of the rubber glove without its objections; it is very thin, very soft and pliable, and therefore does not so much interfere with the sense of touch, and does not in any manner constrict or cramp the hand, and yet it is so resistant and adhesive that it will withstand the manipulations of the longest operation without flaking off; it takes no longer to apply than the ordinary glove, since it dries in about the time it would take to get a well-fitting rubber glove on, and yet it is absolutely without stickiness; and finally it seems not to be at all irritating while on, or in the subsequent taking off with the spirit.

It has a further advantage over the glove in that it may be just as easily applied to the prepared field of operation, protecting this, and at the same time making it much easier to pick up the skin with the fingers.

Hands covered with this coating may without smarting or damage to the skin be washed in a five-per-cent. solution of formalin, which is not an inconsiderable advantage in disinfection.

A further recommendation is the employment of the material in the holding of post-mortem examinations or in doing any thing which would be apt to infect the surgeon's or the accoucheur's hands. It ought to be found very useful in obstetrics.—*American Practitioner and News.*

## TREATMENT OF COMPLICATED FRACTURE OF THE NECK OF THE HUMERUS.

Farquhar Curtis (Annals of Surgery, March, 1900) reports three cases of fracture of the neck of the humerus with dislocation of the upper fragment treated by operation. Careful consideration, based on his own and previously recorded cases of the relative merits of reduction, has led the author to the following conclusions: (1) In fracture of the upper end of the humerus with displacement of the upper fragment from the glenoid cavity, when proper attempts at simple reduction under general anesthesia have failed, operative measures should be resorted to, unless shock, other injuries, or extensive damage to the soft parts about the shoulder justify delay; (2)

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anterior displacements require an anterior incision, and subglenoid or posterior displacements require a posterior incision, probably by Kocher's method; (3) the head of the humerus should, if possible, be restored to its place, and resection should be resorted to only when reduction is impossible or likely to cause such extensive damage to the parts, or such prolongation of the operation, as to increase the risks of wound infection or of shock; (4) resection will probably give a better result in fracture of the anatomical than in that of the surgical neck of the humerus, but reduction is to be preferred in both cases; (5) asepsis is an indispensable requirement for a good functional result, and operative interference in this class of injuries should not be undertaken except under aseptic conditions; (6) motion should be begun in the joint as soon as the wound has healed—in ten to fourteen days after the operation.—*The Medical Age; American Practitioner and News.*

## SOME REMARKS UPON THE TECHNIQUE OF OPERATIONS DESIGNED TO CURE, RADICALLY, OBLIQUE INGUINAL HERNIA.

F. D. Bird lays stress on the following points: the skin incision to be made well above Poupart's ligament and well away from the pubes, the separation of the fibres of the external oblique aponeurosis at a suitable spot, the separation being carried well toward the muscular portion; the sparing of the external ring; the dislocation but partial of the cord from its bed, and the elimination of the sac from above and therefore the preservation of the nerves, the whole to be accomplished with little or no bleeding—an advantage to be attained with great gentleness and the use of dissecting forceps. Apart from the unworkmanlike appearance of a sloppy operation area, bleeding much inconveniences the surgeon and damages the tissues. It obscures the view, necessitates constant sponging, and irritates the delicate areolar planes, which become more or less loaded with blood not capable of being removed. The serous exudation is much greater and the tissues are much weaker and sodden. In addition to these immediate disadvantages there is the grave though unlikely occurrence of thrombosis in the veins of the cord with its possibilities of pneumonia and other distant disasters. The absence of the deep sutures is a gain in two directions: the unimpeded muscle acts as nature meant it to, and there is no foreign body at all in the depths of the wound, no silk with tension on it, and no overchemicalized catgut.—*Lancet. N. Y. Med. Rec.*

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## ANKLE SPRAINS.

Edward H. Ochsner recommends a method of treatment which consists in careful and systematic strapping with rubber adhesive straps. These are cut from half to three quarters of an inch in width, and the proper length, the width depending upon the size of the limb. The foot is held at slightly less than a right angle and a trifle everted. One end of a long strap is applied to the inner surface of the foot near its posterior end, brought under the heel, and up on the outer posterior surface of the leg to within a few inches of the knee. At the lower end this falls into the depression just posterior to the external malleolus. A shorter strap is now applied by placing one end to the inner surface of the heel near the sole of the foot, then bringing it around over the tendo Achillis to the outer surface of the foot, making it cover the first strap at a right angle, and passing along parallel to the under border of the sole of the foot, then over the dorsum of the little toe. Another long one is now applied, anterior to the first, overlapping it about one-third of its width; then a short one, and so on alternately until the outer anterior aspect of the ankle is reached. A hard-rolled bandage is placed over all, and the patient directed to lie still with the foot elevated until the warmth of the body has caused the plaster to adhere firmly. As a rule, the patient can walk with reasonable comfort after a few hours.—*Medicine.*

## METHYLENE BLUE IN GONORRHEA.

Methylene blue administered internally will cure gonorrhea in from four to seven days. It is specially fatal to the diplococccus which is the specific cause of the disease. The pyrogenic bacteria that make gonorrhea a mixed infection succumb very rapidly to this germicide. It should be given in one-grain gelatine capsules three times a day, and after the fourth day reduce to twice a day. If it causes an irritation of the neck of the bladder, combine with oil of nutmeg. The following may be used:

℞ Methylene blue..... gr. I.
Oil of nutmeg..... gtt. I.
Oil of sandalwood..... gtt. II.
M. ft. Caps. No. 1.
S. One capsule three times a day.

It should not be continued for more than ten days. During this time instruct the patient to drink plenty of water. —J. A. O'Neil in *Medical Record.*

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# Therapeutic Notes.

## Cystitis.

℞ Liquor potassæ..... ʒ ij.
Mucil. acaciæ..... ʒ i.
Tinct. hyoscyami..... ad ʒ iji.
M. S. Teaspoonful every four hours.

—Burnside Foster.

## Pruritus Ani.

℞ Sodii hyposulphit..... 30 parts.
Acid. carbol..... 5 "
Glycerini..... 50 "
Aquæ..... 450 "
Apply frequently by means of wet compresses.

—*Practitioner,*

## Mouth Wash and Gargle for Sweetening the Breath.

℞ Acid. salicylici,
Sodii bicarb.,
Sacchari..... āā gr. xv.
Spt. vini rect..... ʒ i.
Spt. menth. pip..... gtt x.
M. S. Teaspoonful in a small cupful of hot water.

—Palmer.

## Hemorrhoids.

℞ Chrysarobin..... gr. xij.
Iodoformi..... gr. v.
Ext. bellad..... gr. viij.
Petrolati..... ʒ i.
M. S. Apply.

—*Jour. de Méd.*

## Painful Menses.

℞ Codein..... gr. i.
Chloral
Ammon. brom..... āā gr. xv.
Aq. camphoræ..... ʒ i.
M. S. From a quarter to half the quantity before retiring. Repeat as indicated.

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### CREOSOTE WINE.

℞ Creosote..... ʒ ss.
Tinct. gentian..... ʒ i.
Spir. vini rect..... ʒ viij.
Vini xerici..... .q.s. ad Oij.

In tuberculosis a dessertspoonful several times a day unless much fever is present.

—*Nouveaux Remèdes.*

### DYSENTERY IN CHILDHOOD.

℞ Cocain muriat..... .05 cgm.
Ergotin..... .50 "
Ext. opii..... .10 "
Aristol..... .25 "
Ol. teobrom..... q.s.

M. ft. supposit. No. x. S. One every two to three hours.

—*Medical Times and Hospital Gazette*, June 9.

### PRURITUS.

Alkaline baths; starch and linseed meal baths; the continuous bath; Turkish and vapor baths.

℞ Ac. carbol, liq..... ʒ i.
Liq. potassæ..... ʒ ss.
Aquæ.....ad ʒ viij.

M. ft. lotio. S. Apply as required.

—EVANS.

### GASTRIC CATARRH.

℞ Ac. hydrochl. (C. P.)..... 2.5 gm.
Ac. azotic..... 0.8 dgm.
Spt. vini rect..... 18. gm.
Aq. font..... 150. "
Syr. limonis..... 100. "

M. S. Teaspoonful in half a glass of water after meals.

## Jottings.

### ERYSIPELAS.

Apply mercurial ointment either in its full strength or diluted with other ointments according to the nature of the case.—DEMATTEIS.

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MEASLES with unconsciousness, delirium, carpologia, involuntary evacuations, etc., was markedly improved by an injection of 10 c.c. of antistreptococcus serum.—EDGAR GILLRIE.

### MYOCARDITIS.

Caffeine in small dose varying from day to day may be kept up for years with benefit in a great variety of chronic heart affections. It is especially indicated in weakness due to disturbance of pulmonary circulation.—LEMOINE.

### ECLAMPSIA.

In coma introduce a stomach tube and inject a solution of chloral (gr. xlv. to lx.) directly into the stomach. If given by the rectum it is often expelled. When the mouth cannot be opened, pass through the nasal fossæ.—FOCHIER.

MORPHINE is depended upon at the Willard Parker Hospital to maintain the heart's strength in diphtheria. Small doses hypodermatically (gr. $\frac{1}{8}$–$\frac{1}{6}$) are given. Strychnine, alcohol and nitroglycerine are also employed.

### REFLEX COUGH IN CHILDREN.

Treat the cause. Hacking night-coughs are mostly due to nasopharyngeal obstruction. Paroxysmal hacking cough in emaciated children with normal temperature is held by Warner, of London, to be due to unbalanced central nerve action.—*Pediatrics.*

### ENTERIC FEVER WITH EXCESSIVE DIARRHŒA.

Give compound tincture of bezoin beginning with ℥ v. in water every two hours, and double the dose if the diarrhœa does not markedly decrease within twelve hours Besides the antiseptic there is supposed to be an antipyretic action.—J. C. POTTER.

### TO BRING ON LABOR.

The use of the Krause sound or the Farnier balloon are means largely employed. They prepare for rather than provoke labor. The Farnier divulsor at times gives good results when the part presses upon the neck. Manual dilatation is the method of choice, for it permits of complete and rapid dilatation, and should be adopted in all cases in which it becomes necessary to terminate labor quickly.—LÉON WEIL.

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THE

# CANADA MEDICAL RECORD

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# Editorial.

## FRIGHTENING CHILDREN.

People who have the care of little children vary in opinion as to the best means of punishing them, for even the best of little people need correction at times. The mother is without doubt the person to whom this duty belongs, and it is her paramount duty to see that it is never deputed to any one who will frighten the child. Nurses who are properly enough forbidden to administer corporeal punishment are very apt to fall back on some such methods if not carefully warned against them and due supervision exercised to see that these admonitions are not neglected. It is true, perhaps, that the imaginary person who was supposed to be always coming after naughty children—the bogeyman, in fact, of our own childish days—is a being of the past. But he has many relations closely resembling him, and on so important a matter mothers ought to be watchful,

If a child is constitutionally nervous it is no use to think that it can be made different by force. Argument, too, in many cases, only intensifies the terrors which children often feel if left alone in the dark, and gives definite expression to fears which are purely imaginary. Many people argue that a child who is afraid to be left alone or to go into a dark room

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ought to be made to do either of these things in order to find out that no harm will come to him. Now, children are seldom really afraid unless they have been made so, and it is a curious fact that the most timid child shrinks from disclosing his fears to any one. In such a case some one has certainly warned him that worse things will happen if he dares to disclose the reason of his alarm. Very often it is the simplest thing which has been made to appear so terrible under certain conditions.

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## TAKING COLD.

Colds are probably the most common ailment in the world. They are always disagreeable and oftentimes dangerous. A person in good heath, with fair play, easily resists cold, but when the health flags a little and liberties are taken with the stomach or with the nervous system, a chill is easily taken, and, according to the weak spot of the individual, assumes the form of a cold or pneumonia, or it may be jaundice. Of all causes of "cold" probably fatigue is one of the most efficient. A jaded man, coming home at night from a long day's work, a growing youth losing two hours' sleep over evening parties two or three times a week, or a young lady heavily "doing the season," young children overfed and with short allowance of sleep, are common instances of the victims of "cold." Luxury is favorable to chill taking; very hot rooms, feather beds, soft chairs create a sensitiveness that leads to catarrh. It is not, after all, the "cold" that is so much to be feared as the antecedent conditions that give the attack a chance of doing harm. Some of the worst "colds" happen to those who do not leave the house or even their beds, and those who are most invulnerable are often those who are most exposed to changes of temperature, and who by good sleep, cold bathing and regular habits preserve the tone of their nervous system and circulation. Probably many chills are contracted at night or at the fag end of the day, when tired people get the equilibrium of their circulation disturbed by either overheated sitting or underheated bedrooms and beds. This is specially the case with elderly

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people. In such cases the mischief is not always done instantaneously or in a single night. It often takes place insidiously, extending over days or even weeks.

## LAUGHTER AS MEDICINE.

For every good hearty laugh we indulge in there is a day taken off our age. Why should we take life so seriously? Cannot we labor as well, or better, accomplish as much and enjoy life as we go along, if we keep on the watch for every possible opportunity for a good, blood-stirring, pulse-tingling laugh? Let us try it for a year. Let us put away all those wrinkle-producing, skin-withering, blood-drying, heart-narrowing feelings of envy, spite, jealousy and secret hatred; those petty, penny-grasping, soul-contorting, narrow-minded ambitions and desires, and make up our mind to live to enjoy living as long as we do live, and to live as long as we can. Joy is the sunshine of the heart, and cheerfulness and honest mirth bring forth the blossoms and unfold the leaves, and their fragrance sweetens all our lives and the lives of others. Let us not worry. Worry drains the system of its vitality and shortens our lives. Fun is better for a sickly child than medicine, has been said. Are we not children grown a little older? and is not mirth the best of medicines?

Let us laugh, then, as we go along, and enjoy every moment of time as it passes, keeping with us eternal youth.

## CANADA A HEALTHY COUNTRY.

The result of the Dominion Census has proved long ago that Canada was one of the healthiest countries in the world to live in. Some, however, were inclined to doubt the data upon which this fact was based. It has, however, quite recently been established by one of our largest Canadian Life Companies—the Canada Life—that the Census was correct. The data which forms the foundation for this statement consists of tables, recently published, in which 35,287 lives are considered. Of this number 19,419 were living at the close of the observations.

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# Book Reviews.

**Saunders' Question-Compends—Essentials of Diagnosis.** By Solomon Solis-Cohen, M.D., Professor of Clinical Medicine and Therapeutics in the Philadelphia Polyclinic, etc., etc., and Augustus A. Eshner, M.D., Professor of Clinical Medicine in the Philadelphia Polyclinic, etc. Illustrated. Second edition. Revised and enlarged. Philadelphia, W. B. Saunders, 1900. Canadian agents, J. A. Carveth & Co., Toronto. Price, $1.00.

This volume, which represents the second edition of "Essentials of Diagnosis," is a neat work of four hundred pages. It is well bound and well printed. It is reliable, concise and up to date.

It opens with a very complete chapter on the general principles and methods of diagnosis. Then follows a special description of each disease by which it may be distinguished. This is followed by the differential diagnosis. The different diseases resembling the one in question, and the points of difference are clearly pointed out.

It is a little book that will be found exceedingly useful to the practitioner as well as the student. W. G. S.

**Annual and Analytical Cyclopædia of Practical Medicine.** By Charles E. de M. Sajous, M.D., and one hundred associate editors, assisted by corresponding editors, collaborators and correspondents. Illustrated with chromo lithographs, engravings and maps. Volume V. The F. A. Davis Company, publishers, Philadelphia, New York and Chicago, 1900.

This volume includes a consideration of subjects between "Methyl Blue and Rabies" in alphabetical order. The editor states that this fifth volume "has proved the most arduous one to prepare of the entire series, involving as it does almost every specialty—otology, laryngology, ophthalmology, neurology, pædiatrics, obstetrics, therapeutics, etc., besides the sections usually classed under general medicine and surgery."

It contains a number of excellent articles; in these and throughout, in all, the chief features are pointed, terse descriptions, giving all the newer aspects of the various questions, and only that which has a practical bearing. Morphinomania, by Norman Kerr, is ably treated. The symptoms and treatment are given fully, as well as the bearing of such cases towards life insurance. He is of opinion, contrary to Mattison's view, that heredity has something to do with these cases, and that every variety of inebriant, inherits either the inebriate diathesis or some germane neurosis; myxoedema is exhaustively treated by Chas. E. de M. Sajous, the article being illustrated by a beautifully colored plate showing the physiological importance of the thyroid gland as illustrated by its vascular relation.

"Nursing and Artificial Feeding," by L. Emmett Holt, and Linmaus Edfard La Fetra, is an exceedingly valuable article, giving the latest points in regard to modification of milk, sterilization and pasteurization rules, for artificial feeding, etc. Other important articles are: The Disorders of Pregnancy, by Dr.

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Currier, and Abnormal Parturition, by Drs. Grandin and Marx; Pleurisy, by Dr. Alex. McPhedran, Toronto; Catarrhal Pneumonia, by Dr. Solomon Solis-Cohen; Lobar Pneumonia, by Dr. Thos. G. Ashton; Orthopædic Surgery, by Gwilym G. Davis, etc. This volume more than sustains the claims of this Annual and Cyclopædia, to be an exhaustive yet condensed presentation of the most modern views and advances in all the branches of medicine. J. B. Mc.C.

**Simon's Clinical Diagnosis.** A Manual of Clinical Diagnosis by Microscopical and Chemical Methods. For Students, Hospital Physicians and Practitioners. By Charles E. Simon, M.D., late Assistant Resident Physician Johns Hopkins Hospital, Baltimore. In one very handsome octavo volume of 563 pages, with 136 engravings and 18 full-page colored plates. Cloth, $3.50 net. Lea Bros. & Co., Philadelphia and New York, 1900.

Clinical diagnosis interests every practising physician, and the more proficient he is in the various methods employed towards this end the greater will be his success. This new edition of Dr. Simon's popular book deals with the latest and most approved methods of employing the microscope and chemical tests in recognizing disease, and, as might be expected, with the thorough revisal and new matter added, is much more complete than either of the previous editions issued during the last four years. The description of methods is clear and readily comprehended, so that, with the reagents and the instruments indicated and this work. a physician can, with a little practice, apply these latest methods for precise diagnosis.

The blood is first studied in regard to its general characteristics, its chemical examination, then its microscopic examination, its bacteriology and parasitology; this chapter has received more additions than any other, and represents the most recent aspect of the methods now approved. Chapters are devoted to the secretions of the mouth; the gastric juice and gastric contents; the feces; the nasal secretion; sputum; urine; transudates and exudates; cystic contents; cerebro-spinal fluid; semen; vaginal discharge, and the secretion of the mammary glands. The book is embellished by numerous colored plates, and cuts, illustrating instruments, organs, tissues, secretions, parasites, micro-organisms, blood, crystals, etc. It is perfection itself as a guide to student, practitioner or teacher in this important department of daily work.

J. B. McC.

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# PUBLISHERS DEPARTMENT.

The *Quarterly Review* for October—published in London October 24—will contain an important article on "The Coming Presidential Election," analysing the issues of the campaign and forecasting its result. The article will be reprinted entire in *The Living Age* (Boston) for November 3—ready November 1. According to the custom of THE QUARTERLY the article is unsigned, but it is written by Mr. Edward Stanwood, author of "A History of the Presidency."

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CANADA
MEDICAL RECORD

NOVEMBER, 1900

# Original Communications.

## PROGRESS OF GYNECOLOGY.

By A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., London.

Professor of Clinical Gynecology in Bishop's University; Surgeon-in-Chief of the Samaritan Hospital for Women; Gynecologist to the Montreal Dispensary; Surgeon to the Western Hospital, Montreal.

One of the most practical articles written during the last three months is the one read by Dr. William Gardner, of Montreal, at the Ottawa meeting of the Canadian Medical Association, every word of which will be endorsed by gynecologists generally throughout the world. Much of it was devoted to the mistakes he had met with among cases sent to him by general practitioners, although he did not spare himself, frankly admitting and describing some of the mistakes he had made himself. In order to reduce the number of these errors in diagnosis, he urged the examination of the patients on a hard deal table instead of on a soft bed or couch. Also many of the mistakes were due to the examination being made with the rectum and bladder full. The rectum, of course, should be emptied by enema at home, but the bladder, he thought, might with advantage be emptied by catheter in the office by the physician, as thereby a pure specimen of urine could be obtained for analysis. It is often difficult to make a thorough bimanual examination without an anæsthetic on account of the tension of the abdominal muscles. Dr. Gardner suggests making a series of circular movements over the lower abdomen, gradually narrowing the circle which will cause the muscles to relax by taking them off their guard. Dr. Gardner urged greater caution in the use of the sound, believing that many women had lost their

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lives by it. He thinks it a very dangerous instrument, the use of which should be extremely limited. I know of one general practitioner who does not believe in specialists in general, nor in gynecologists in particular, who, by attempting to put up a fixed and retroverted uterus with the sound, not only perforated the uterus but also tore open a sealed up pus tube, with the result that the patient immediately developed a general peritonitis, and died three days later. Although I use the sound less and less, as I am more and more able to diagnose the size and position of the uterus by bimanual palpation, I still use it occasionally in clearing up the diagnosis when the whole pelvis is filled with a solid mass. When I am in doubt whether the mass at the back of the uterus is a pus tube and ovary or a retroflexed and retroverted uterus, I very gently try which way the sound enters. But, if there is the slightest difficulty in introducing it, my invariable rule is to stop at once and to make the best diagnosis I can without its aid. The experienced gynecologist is the only one who can use the sound with safety, and he is the one who requires to use it least. Dr. Gardner finds that mistakes in diagnosing displacements of the uterus are the most common; I can also endorse this statement and can remember a great many cases which have come or been sent to me because they could not endure a pessary, which was inserted for a supposed retroversion of the uterus, but which on examination I found not to be a retroversion at all, but, on the contrary, a pair of diseased tubes and ovaries cemented into Douglas' *cul de sac* and against which the pessary was pressing. Dr. Gardner also calls attention to the importance of diagnosing displacements of the kidney. This is emphasized by some experiences of my own, for, after removing both tubes and ovaries and the vermiform appendix and performing ventrofixation, much to my disappointment the patient has still complained of reflex symptoms which were at once removed when I had discovered that the right kidney was displaced, and fastened it up. He thinks that mistakes are often made in the diagnosing of pregnancy, and he mentions a case where a woman had been tapped several times for a supposed ovarian cyst when all the time she was pregnant. While agreeing

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with him, I would add that, if we rely upon the woman's statements, yet we will often be led into error, but if we rely upon our own bimanual examination we will rarely be so. Over and over again have women come to me for some uterine trouble, some of them even having urged me to operate on them for a tumor, who on examination I at once declared to be pregnant. This they indignantly denied being possible, basing their assurance on the fact that they were widows or that their husbands had promised not to impregnate them or because they were wearing a little piece of sponge which of course was lost in the vaginal vault; or they were using a syringe after intercourse; all of which reasons, of course, weigh as nothing as compared with the result of a bimanual examination.

Dr. Gardner's paper closed with a reference to some mistakes which had been made in diagnosing tubal pregnancy. These mistakes would be very much reduced in number if every one were to adopt the rule I have laid down for myself, namely, to make a careful vaginal examination in every case of irregular hemorrhages, or of supposed membranous dysmenorrhœa, and if a mass is felt on either side or behind the uterus which should not be there, and if this mass remains after the bowels have been well emptied, then to take it for granted that it is an ectopic gestation unless we have proof to the contrary. Since beginning this article I have operated on my fourteenth case of tubal pregnancy, all of whom have recovered so far. Some ten of these were removed before rupture. But the women came with a pain in their side and more or less temperature, and on examination a mass was felt which should not be there. This I considered quite enough to justify me in operating. With one exception all these fifteen cases were diagnosed before operation, the exception being one case diagnosed as a fibroid tumor, owing to the pregnant tube being intimately cemented to the uterus, and the two as large as a fœtal head, being wedged into the pelvis under great tension, which gave it a solid feeling. The prolonged and irregular bleeding was thought to be due to the fibroid, when it was really from the tube. It is true that, by following my rule, I opened the abdo-

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men and removed dangerous pus tubes in about ten, and two twisted ovarian cysts, and thus proved that they were not tubal pregnancies, as I had half suspected.

INSANITY IN WOMEN.—There have been several recent papers of great interest on this topic, one of the best being the one by Dr. McNaughton Jones, entitled: Affections of the female genitalia, as causal factors in the etiology of neuroses and insanity and their special bearing upon the operative treatment of the insane. Dr. McNaughton Jones before writing his article took great pains to obtain the opinion of many superintendents of insane asylums, as well as of leading gynecologists, and the following are the general conclusions to which he has come: 1st. That a great many of the women who fill the asylums for the insane are there directly because of some disorder of the genital organs. This is proved by the considerable number of complete cures following operations for the removal of the diseased conditions. Dr. Hobbs, for instance, of the London, Ont., asylum reports that during five years he had eight hundred insane women under observation, and, of these, two hundred and twenty underwent a gynecological examination. One hundred and eighty-eight or eighty-five per cent. of those examined had distinct and in many cases serious lesions of the pelvic organs, there being 371 lesions in the 188 patients. It is interesting to note the nature of these lesions; sub-involution or endometritis in 132, diseased or lacerated cervices in sixty-two, retroversion or prolapses in sixty-six, myomata in sixteen, malignancy in two, disease of the adnexa in thirty-three, various lesions of the vagina in thirty-seven. Eighteen women suffered from dysmenorrhœa or menorrhagia. These were cases especially selected as likely sufferers from pelvic disease, and were about twenty-five per cent. of the entire patients in residence, during the time in which these investigations were conducted. There were 311 operations performed on the 173 women, with the result that 42 per cent. were completely cured mentally; 24 per cent. were improved mentally; in 32 per cent. there was no change mentally, and 2 per cent. died. Since gynecological surgery has been introduced into that asylum, the percentage of

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recoveries has risen from 33 per cent. to 51 per cent. I have noticed in about twenty of my own cases that a mild form of insanity was cured by a gynecological operation. The most striking results followed ventrofixation in women who were suffering from retroverted uterus with diseased tubes. Several of these had a suicidal mania, which disappeared immediately after the operation, and has not since returned. 2nd. It would appear that gynecological operations are very rarely followed by insanity in women who were previously sane. The cases of acute delirium lasting only for a day or two do not count, for they are mostly due to sepsis or iodoform poisoning. As far as I am aware, very little gynecology has been done on the insane women of this province, but a great field for doing good lies open to some one. In my opinion every insane woman, married or single, should be submitted to an examination under anæsthesia, for even single women very frequently suffer from severe retroversion and prolapse.

# Selected Articles.

## PRESIDENTIAL ADDRESS ON THE STUDY OF CLINICAL MEDICINE.

*Delivered at the First Meeting of the Clinical Society of London for the Session* 1900-01.

By SIR R. DOUGLAS POWELL, BART., M.D., F.R.C.P.,
Consulting Physician Middlesex Hospital; President of the Society.

### Empirical Use of Remedies.

Sir Thomas Watson, in his inaugural address, 1868, laid it down as the great object of the Society to attain "more exactness of knowledge and therefore more direct and intelligent purpose and more successful aim, in what is really the end and object of all our labours—the application of remedies for the cure and relief of disease."

Whilst rational therapeutics must follow in the wake of advancement in pathology and etiology, it is very remarkable how many of our remedies have preceded in their employment any adequate knowledge of the maladies for which they were

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used. Thus for nearly four centuries mercury has been used for syphilis, and I doubt if anyone could even now tell the precise method of its action. Dr. Withering 115 years ago was shown a family receipt for dropsy concocted by an old woman in Shropshire, in which he recognised foxglove as the essential ingredient. Yet, familiar as we have so long been with digitalis, it is only within very recent years that we have had, piece by piece, explained to us, by physiological experiment, the phenomena of slowing and increased regularity of pulse with concentration of force and an increased flow of urine, which bedside observation had taught us to be the beneficent effects of the drug. Cinchona bark has for three and a-half centuries been used for intermittent fever, and Fowler's ague drops were employed in the same disease more than a hundred years ago, yet it is only with the discovery of the ague plasmodium by Laveran (1880), twenty years ago, that the use of quinine and arsenic could be regarded as rationally justified. Again, no one who has any recollection of rheumatic fever in the days preceding the introduction of the salicin treatment by Dr. Maclagan in 1874 can fail to appreciate the great value of that therapeutical discovery, yet our knowledge of the exact method of its action is at present but inferential.

We may then be thankful for much in empiricism which is but unexplained observation, the well-attested results of which we should be as foolish to reject because unexplained as to refuse to profit by the sunshine until we knew the composition of its rays The great object of this Society is to gain increased knowledge of practical medicine by "the collection of cases, especially such as bear upon undetermined questions in pathology and therapeutics," and by pursuing it concurrently with the advance of contributory scientific research and discovery we have vastly improved our handling of drugs often empirically found, in decision and definiteness, when to employ, how far to push, and when to withhold.

## The Etiology of acute Specific Diseases.

Great strides forward have been made since twenty five years ago; Sir W. Jenner spoke here of "the contagious quality of acute specific diseases" as "a something given off from some part of the sick which can, when properly applied, excite the same disease in another person, and which can excite no other disease." What that something is has been rendered plain to us mostly within the last fifteen years in nearly every one of the acute specific diseases, and in some others which, although specific, are not acute. Leprosy,

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pyæmia, dysentery, enteric fever, ague, tuberculosis, pneumonia, diphtheria, erysipelas, cholera, tetanus, syphilis, plague may be enumerated, the organism specific to each of them having in the sense employed by Jenner been discovered. This exactness of knowledge of the *materies morbi* of these maladies must ultimately give greater precision and effectiveness in treatment, and especially in prophylactic treatment. The report of a Committee of this Society on the periods of incubation and contagion of specific fevers is of standard value and authority, and the further inquiry as to the duration of infectiousness in convalescence, which must be based upon bacteriological observations, is now possible, and might properly be undertaken by the Society. Already some fruits have been gathered in therapeutics. The triumphs of surgery that have ensued upon increasingly exact recognition of the organisms responsible for suppuration so fill the mind's eye that it can scarcely penetrate to the Dark Ages that ended less than a generation ago. The great terror of the early days of diphtheria has been almost removed by antitoxin treatment; the prophylactic treatment of tuberculosis has been greatly stimulated. A measure of success, encouraging for the future, has at least been attained in tetanus, scepticæmic conditions, plague, cholera, anthrax, and we hope, this session, to receive some valuable contributions presenting for discussion and comparison the experience of those who have in the African war and in India watched the results of the preventive inoculations against enteric fever devised by Professor Wright. Important, however, as are these increased powers of prophylaxis and treatment, the direct fruits of recent combined laboratory and clinical labours, encouraging, too, as they are for further work, we must yet admit disappointment that they have failed to help us in some of our more homely diseases—diseases which in so great a degree account for the discomforts and death-rates of large communities.

The death-rate from pneumonia has remained unaltered for fifty years; the influenza bacillus thwarts our best efforts and carries on its guerilla warfare year after year, with a gay elusiveness worthy of a DeWet, nor can we yet cure a common cold.

## Proclivity, Heredity and Immunity.

In the light of recent combined laboratory and clinical work the ideas of proclivity, heredity, immunity and epidemic influence have acquired a more definite and practical shape—nay, have been resuscitated from an oblivion threat-

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ened by the natural intolerance of new inquiry for old notions. We are learning how such accidents as shock, chill, pyrexial incidents, local injury, checked secretion, etc., may supply the exciting cause of acute general disease—for example, rheumatic fever, ague, pneumonia, influenza, coryza, acute tuberculosis—since in some cases we know, and in others we may infer, that the organism, specific to such diseases, may long dwell with us in abeyance until permitted to assume active cultivation by depression or modification of the vital conditions under which they have been held restrained. The same conditions that lead up to a common cold in an otherwise healthy man would elicit an attack of ague in a fair proportion of persons who harbour the germs of that disease. And, as I have elsewhere hinted, a careful study of the antecedents and bacteriology of a common cold would probably prove rich in illustrations and elucidations of this thesis in its application to many allied diseases, and in competent hands would furnish matter for a paper well worthy the attention of this Society, or to form the graduation thesis for a university degree.

The question of artificial immunity must become one of increasing importance to our military, naval and civil services, as our improving home sanitation renders us increasingly sensitive to diseases which must for long remain endemic in the distant or tropical regions of our vast empire. With our home populations, except for small-pox, the need of artificial immunity is unlikely ever to be felt, and it is to be hoped that the day will even come when we shall no longer need to devitalize our milk and drinking water, killing the kindly ferments in order to protect us from adventitious and poisonous microbes.

Sir Prescott Hewett, in his presidential address in 1872, noted the fact that pyæmia occurred, not only amongst the crowded inmates of hospital wards, but also in private patients isolated in luxurious and sanitary houses. Dr. Greenhow—a great sanitary authority in his time—referring in 1879 to Sir Prescott's experience, suggested "that it would seem to indicate some state of the patient predisposing him to the disease, or possibly some peculiarity of season favouring its development. We smile with the lofty tolerance of more exact information that such inferences should pass muster in this Society only twenty years ago. Cases, however, I venture to think, come within the experience of physicians and surgeons that would justify Dr. Greenhow's shrewd remark, cases in which incidents of a septic kind—for example, phlebitis and secondary embolism of organs—occur after operations for appendicitis, varicocele, varicose

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veins, thyroid resections, not to mention parturition and operations about the nose and ear passages. In some of these cases which have come under my observation the accidents could be accounted for by no imperfection in the operation nor in the sanitary surroundings of the patient. The wounds have soundly healed, yet the patient has perhaps an embolic pneumonia or a cardiac embolism. These cases are not very frequent, but one meets with them, and they are more common, if I may judge from my own experience and inquiry in private than in hospital practice. They are, too, the more striking when met with, since they are relatively more frequent in slight than in very severe operations. My impression is that they are accounted for by an unpreparedness of the patient for surgical injury. In some acute and urgent cases, for example, of strangulated hernia, suppurative appendicitis, and the like, the surgeon has no option but to take the risks and operate immediately, but in chronic cases a few days' preparation, or, if necessary, a few weeks' regulation of the patient's habits and secretions would serve to purify him of those effete products of impaired, imperfect or exuberant tissue change and inadequate excretions which cause a morbid reaction to local injury. The methods of procedure may be aseptic, but the patient in many instances can scarcely be said to be so.

## Electricity, Myxœdema and Organotherapy.

In the lifetime of our Society the use of electricity for diagnostic purposes has made great strides, the employment of the electro-magnet for detecting and removing foreign bodies, especially from the eye, of electric light for exploring hollow cavities, and lastly of radiography, have been closely watched and studied here with excellent results for diagnosis, but little, so far, of a direct kind for treatment. One of the most valuable contributions to the science of medicine to which this Society has largely contributed is the description and through elucidation of the disease now known as myxœdema, having been first so named by our esteemed member and late treasurer, Dr. Ord. Sir William Gull was the first to describe the disease under another name, and it was afterwards thoroughly investigated by Dr. Ord, and reported upon in a special volume of our *Transactions* by a Committee presided over by him. Apart from the intrinsic value of investigations which have thoroughly established the nature and treatment of this important disease, the study of myxœdema and its treatment by thyroid extract gave an impetus to, if it did not actually originate, the pathological

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and physiological lines of thought and experimental inquiry, which have shown the influence of secretion products absorbed from ductless glands, and from some glands which are not ductless (ovary, testicle), upon mental and physical health and upon formative symmetry. The sexual glands, the adrenals, bone marrow, spleen and pituitary body have in this comparatively new light been reinvestigated, and the practical physician is already reaping the fruits therefrom in a greater insight into many previously inexplicable groups of symptoms. The most recent and suggestive outcome in this category is that of the relationship between disease of the pituitary body and that want of growth-control which characterises acromegalous disease, the first case of which recognised in this country was brought before this Society by Mr. Godlee.

Another idea that has arisen from the closer association of laboratory and clinical research is the analogy between the affinity of stains for certain tissues and the selective tissue-affinity of certain poisons. The affinity, for instance, of the toxins, of the tetanus and diphtheria bacillus for nerve tissues, and the very analogous selection of the nervous system by the influenza poison, are rendered tangibly intelligible to us from our laboratory experience of the affinity of different stains for muscle, nerve, fat, cell nuclei respectively.

I must not further trench upon your patience by reflection founded upon the work done by this Society and a glance at some of the questions which it has helped to solve. The retrospect is laden with encouragement and suggestions for work yet to do.—*British Medical Journal.*

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# Progress of Medical Science.

## MEDICINE AND NEUROLOGY

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine University of Bishop's College; Physician Western Hospital.

### SOME "SIGNS" IN APPENDICITIS.

In the course of a series of clinical lectures on the various forms of intra-abdominal suppuration, now in course of delivery at Westminster Hospital, Mr. Tubby called

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attention to the importance of certain "signs" in the diagnosis of appendicitis. In his opinion the most common sign is rigidity of the abdomen. As a rule the whole abdomen is distended and somewhat rigid or tympanitic; later on, at the second or third day, local rigidity and tenderness are more marked. If the rigidity remain persistent it indicates acute general peritonitis. The tenderness, he observed, is best marked at McBurney's spot, and the reason that this the point of greatest pain is that it is just at this part that the appendix arises from the cæcum. Though we may have appendicitis without the sign of any tumour, a swelling is generally present on the second or third day in the right iliac fossa; with a long appendix hanging in the pelvis the tumour cannot be felt. The tumour may consist of intestine, peritoneum, exudation, and possibly pus, and therefore dullness is not persistent. Should, however, a tympanitic note remain persistent, the signification is that there is gas in an abscess cavity. The formation of pus, without its evacuation, causes the patient to rapidly waste, and the presence of indican in the urine is noticed. In acute appendicitis, with the formation of pus we have an excessive number of leucocytes in the blood, and this has been relied upon by some as one means for the differential diagnosis of appendicitis from typhoid.—*Medical Press.*

## THE TREATMENT OF ASTHMA BY COMPRESSED AIR BATHS.

This peculiar form of treatment can be seen in progress at Ben Rydding and at the Brompton Hospital for Consumption, in connection with which Dr. Wethered recently described the method in the course of a clinical lecture. The curative agency is a system of compressed air baths. The "air bath" holds five or six people, and resembles a huge diving bell. The bath is continued for a couple of hours. The first half-hour is occupied in increasing the pressure of the air from one to nine atmospheres, at which it remains for an hour, and then it is gradually lowered to the normal. It has been found that, if the alterations of pressure are made with any suddenness, the patients experience much discomfort. When the pressure is first put on, the patients feel an uncomfortable sensation, chiefly in the ears and throat, but they can get rid of this by swallowing some liquid. The relief afforded seems permanent. The air is compressed by steam power. A whistle is provided by which, if any patient feels unwell, communication can be established with the attendant, who looks in at one of the

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windows provided. The attendant is always close at hand while the bath is being taken, and periodically looks through the window. In case of any accident occurring to one of the patients, the pressure is of course lowered comparatively suddenly.—*Medical Press*

## CONCLUSIONS REACHED AFTER A STUDY OF TYPHOID FEVER AMONG THE AMERICAN SOLDIERS IN 1898.

(Oration on State Medicine before the Fifty-first Annual Meeting of the American Medical Association at Atlantic City, N. J., June 5-8, 1900.) (By Victor Vaughan, M.D., Journal American Medical Association ; Ann Arbor, Mich., June 9, 1900.)

1. Every regiment in the United States service in 1898 developed typhoid fever.

2. More than 90 per cent. of the volunteer regiments developed typhoid fever within eight weeks after assembling in the state encampments.

3. Most, probably all, of the regular regiments developed typhoid fever within less than eight weeks after going into camp.

4. Typhoid fever not only appeared in every regiment in the service, but it became epidemic, both in the small encampments of not more than one regiment, and in the larger ones consisting of one or more corps.

5. Typhoid fever became epidemic in camps located in the Northern as well as in those located in the Southern States.

6. Typhoid fever is so widely distributed in this country that one or more cases are likely to appear in any regiment within eight weeks after assembling.

7. Typhoid fever usually appears in military expeditions within eight weeks after assembling.

8. The miasmatic theory of the origin of typhoid fever is not supported by our investigations.

9. The pythogenic theory of the origin of typhoid fever is not supported by our investigations.

10. Our investigations confirm the doctrine of the specific origin of typhoid fever.

11. With typhoid fever as widely disseminated as it is in this country, the chances are that, if a regiment of 1,300 men should be assembled in any section and kept in a camp, the sanitary conditions of which were perfect, one or more cases of typhoid fever would develop.

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12. Typhoid fever is disseminated by the transference of the excretions of an infected individual to the alimentary canals of others.

13. Typhoid fever is more likely to become epidemic in camps than in civil life because of the greater difficulty of disposing of the excretions from the human body.

14. A man infected with typhoid fever may scatter the infection in every latrine of a regiment before the disease is recognized in himself.

15. Camp pollution was the greatest sanitary sin committed by the troops in 1898.

16. Some commands were unwisely located.

17. In some instances the space allotted the regiments was inadequate.

18. Many commands were allowed to remain on one site too long.

19. Requests for change in location made by medical officers were not always granted.

20. Superior line officers cannot be held altogether blameless for the unsanitary condition of the camps.

21. Greater authority should be given medical officers in matters relating to the hygiene of camps.

22. It may be stated in a general way that the number of cases of typhoid fever in the different camps varied with the method of disposing of excretions.

23. The tub system of disposal of fecal matter as practiced in the Second Division of the Seventh Army Corps is to be condemned.

24. The regulation pit system is not a satisfactory system of disposing of fecal matter in permanent camps.

25. Our board has recommended that in permanent camps where water-carriage cannot be secured, all fecal matter should be disinfected and then carted away from camp.

26. Infected water was not an important factor in the spread of typhoid fever in the national encampments in 1898.

27. Flies undoubtedly served as carriers of the infection.

28. It is more than likely that men transported infected material on their persons or in their clothing, and thus disseminated the disease.

29. Personal contact was undoubtedly one of the means by which the infection was spread.

30. It is probable that the infection was disseminated to some extent through air in the form of dust.

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31. A command badly infected with typhoid fever does not lose the infection by simply changing location.

32. When a command badly infected with typhoid fever changes its location, it carries the specific agents of the disease in the bodies of the men, in their clothing, bedding and tentage.

33. After a command becomes badly infected with typhoid, change of location, together with thorough disinfection of clothing, bedding and tentage, is necessary.

34. Even an ocean voyage does not relieve an infected command of its infection.

35. Except in case of most urgent military necessity one command should not be located on a site recently vacated by another.

36. The fact that a command expects to change its location does not justify neglect of proper policing of the ground occupied.

37. It is desirable that the soldiers' beds should be raised from the ground.

38. In some of the encampments the tents were too much crowded.

39. Medical officers should insist that soldiers remove their outer clothing at night when the exigencies of the situation permit.

40. Malaria was not a prevalent disease among the troops that remained in the United States.

41. The continued fever that prevailed among the soldiers in this country in 1898 was typhoid fever.

42. While our investigations show that coincident infection with malaria and typhoid fever may occur, the resulting complex of symptoms does not seem to be sufficiently well defined and uniform to be recognized as a separate disease.

43. About one-fifth of the soldiers in the national encampments in the U. S. in 1898 developed typhoid fever.

44. Army surgeons correctly diagnosed a little less than half the cases of typhoid fever.

45. The percentage of deaths among cases of typhoid fever was about 7.5.

46. When a command is thoroughly saturated with typhoid fever it is probable that from one-third to one quarter of the men will be found susceptible to the disease.

47. In military practice typhoid fever is often apparently an intermittent disease.

48. The belief that errors in diet with consequent

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gastric and intestinal catarrh induced typhoid fever is not supported by our investigations.

49. The belief that simple gastro-intestinal disturbances predispose to typhoid fever is not supported by our investigations.

50. More than 80 per cent. of the men who developed typhoid fever had no preceding intestinal disorder.

51. The deaths from typhoid fever were more than 80 per cent. of the total deaths.

52. The shortest period of incubation in typhoid fever is probably something under eight days.

53. One who has lived in a camp in which typhoid fever is prevalent is liable to develop this disease any time within eight weeks after leaving such a camp.—*St. Paul Medical Journal.*

## CHARACTERISTICS OF THE DESCENDANTS OF HEREDITARY SYPHILITICS.

In an exhaustive article, in which all the literature is carefully digested, and to which he adds his own wide experience, Finger comes to the following conclusions regarding the transmissibility of syphilis and the syphilitic manifestations:

1. It must be regarded as theoretically possible that an inheritance of syphilis can take place upon the second and perhaps further generations as upon the first; in this wise that three different manifestations of parental syphilis can be transmitted independently of each other, namely (A) true virulent syphilis, (B) syphilotoxic dystrophic disturbances, and C) immunity.

A. *Transmission of true virulent syphilis to the second generation.*

2. Although this is theoretically possible, up to the present no case of this nature has been brought forward which is entirely free from objections.

3. In order to prove the transmission to the second generation, the following postulates must be proven: (a) The hereditary syphilis of one of the parents must be proven beyond a doubt; (b) Acquired syphilis in the second generation must be conclusively ruled out; (c) The nature of the syphilis in the third generation must be proven to be inherited.

4. In order that there be no doubt that it is a case of inherrited syphilis in the second or third generation, it must make its manifestations at the time of birth, or shortly afterwards.

5. The question of exclusion of acquired syphilis in the sec-

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ond generation is a difficult one, since it is dependent entirely upon negative arguments, and since in each separate case it is impossible to the most conscientious observer to bring his subjective conviction acquired by intimate knowledge of the single case into an objectively unobjectionable form.

6. From the standpoint of the above-mentioned postulates, the majority of the twenty-four observations which up to now have been made in this connection is open to objection, although some (cases of Nunn, Mensinga, Hutchinson) are striking in the highest degree. Still the latter are not conclusive, and, in fact, to be regarded as absolutely conclusive a case would have to conform to the following type:—The mother is hereditarily syhilitic and gives birth to a hereditarily syphilitic child. Shortly after the birth of the same the father of the child is infected with syphilis illegitimately.

B. *Transmission of syphilotoxic dystrophic disturbances upon the second generation.*

7. This question is still more difficult to answer than the first, since the conception of syphilotoxic dystrophic disturbance as manifested by transmission to the first generation is not as yet completely settled and fixed.

8. In spite of previous works in this connection, this question has not been cleared up as yet, because: (a) These syphilitic dystrophies furnish nothing absolutely characteristic. (b) Analogous dystrophies are found in families where all known etiological factors, especially syphilis, tuberculosis, intoxication with alcohol or lead, are wanting. (c) Such dystrophies, if of syphilitic nature, should appear most frequently in the genuinely, hereditarily syphilitic children, but, on the contrary, up to the present, in contrast to a small number of children, who furnish dystrophies together with genuine inherited syphilis, we have a much larger group of children showing no genuine inherited syphilis, but only dystrophies.

9. If we have undoubted general nutritive disturbances, debility, asthenia, infantilism in children of syphilitic parents, still the question would remain whether such disturbances would not have arisen even if syphilis had not been present.

10. In regard to the question of the transmission of dystrophies to the second generation, each case must conform to the following postulates: (a) Hereditary syphilis must be proven beyond a doubt in the second generation; (b) Acquired syphilis in the second generation must be eliminated, (c) Also in the third generation syphilis acquired at an early age must be eliminated.

11. This last point, the elimination of acquired syphilis in

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the third generation, is necessary, because we know now from many observations that dystrophic disturbances in a child may be developed not only after inherited, but also after syphilis acquired early in the suckling period, which may be easily mistaken for a hereditary dystrophy.

12. From this point of view, the thirty-one cases of this kind hitherto described are interesting, but not fully conclusive. Here the especial difficulty lies in the elimination of acquired syphilis in the second generation.

13. From a study of these dystrophies, which have been regarded as syphilotoxic, we must conclude that they become milder and rarer from generation to generation.

14. From this it would follow that syphilis in its influence upon posterity leads less to a degeneration than to a diminution of the race.

C. *Transmission of absolute and relative immunity upon the descendants.*

15. For many years it has been known that the offspring of syphilitic parents possess an absolute or a relative immunity towards the syphilitic infection. This view was based upon several observations: (a) The observation that where syphilis has been endemic for a long time it runs a markedly milder course. (b) The observation that syphilis, brought to people who have never had syphilis, appears there at first with severe manifestations. (c) The finding of sporadic cases of malignant syphilis where the victim's ancestors had been free from syphilis for several generations. (d) The observation that mothers in the contagious stage of syphilis do not infect their healthy offspring (Profeta's law).

16. These observations, although worthy of notice, furnish no unimpeachable scientific proofs of the inheritance of immunity, and can be satisfactorily explained along other lines.

17. On the other hand, there is a considerable number of facts which go to prove that the inheritance of immunity is incontant, to say the least, and which suggest that the doctrine of the inherited immunity of syphilis needs a complete revision.

18. These are: (a) The fact that in acquired syphilis itself the immunity is often transient, reinfection is observed, and that reinfections would perhaps be more frequent if certain factors, social and otherwise, care, routine, marriage, old age, impotence, did not stand in the way of a reinfection. (b) The fact that not a few cases are known in which hereditarily syphilitic (fourteen cases) or syphilotoxic-dystrophic (137 cases) or entirely healthy children (twenty-nine cases) of syphilitic parents infect themselves with syphilis. (c) The

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fact that in these cases not only absolute, but also relative immunity, *i. e.*, an especially mild course of the disease, is not to be found.

19. The fact that in a number of children of syphilitic parents the immunity, if indeed present, was lost at the time of puberty, proves to us that these individuals could not transmit an immunity to their children and descendants.

20. The facts given above, which oppose the view that immunity to syphilis can be inherited, must make us wonder whether we have the right to hold any longer to the doctrine of the unlimited duration of immunity in acquired syphilis, or still further to the thesis of the inheritance of immunity. *Maryland Medical Journal.*

## THE INTERNATIONAL CONGRESS AT NAPLES AGAINST TUBERCULOSIS.

On April 25th this Congress was inaugurated by the King and Queen of Italy in the historic opera-house of San Carlo. The President, Professor Baccelli, welcomed the delegates, who had been sent from every European country (except England), the Congressists who numbered some 1,200, and the members of the "League's" adherents in Neapolitan Society. He alluded to the King's efforts during the cholera in 1884, and to his present visit to wage war against the "phylloxera of human life." He explained the objects of the meeting, and briefly reviewed the question of tuberculosis from Morgagni to Koch. The recent legislation and the prizes offered for the best-planned sanatorium were mentioned. He insisted that the mortality from tuberculosis in Italy was less and more rapidly decreasing than in any other country in Europe, in spite of the number of cases attracted there by the climate, but trusted that the original example set in England would be eagerly followed by Italy in the proper institutions for consumptives. The arrangements for the following days were on the lines of the British Medical Association's meetings. From the mass of communications which covered all the old ground are taken the more original items.

Professor Lannelongue explained his attempt to deduce results as to climate. He inoculated one hundred and fifty guinea-pigs in the pleura with similar doses of tuberculous material. The one hundred and fifty were divided into three lots of equal weights and put to live under different climatic conditions, one lot being retained in the laboratory at Paris, the second lot being sent to Valmont in the country, and the

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third lot to the seaside at Grandes Dalles. The conditions other than climatic were rendered as similar as possible, the experiment lasting eleven months. The mortality curve of the country lot was the highest from the start, the other two lots keeping level for a long time. Toward December the seaside curve rose, and the laboratory curve had the best of it. A second experiment was marred by an accident to one of the lots, but here again the laboratory lot suffered the least, and Professor Lannelongue concluded that the equable temperature and repose of the laboratory were the reasons. The greater thermometric variations of the country and the seaside were followed by rises in the mortality curves. An experiment on these lines, if carried out with men instead of guinea-pigs, might give definite information regarding the sites of sanatoria.

Professor Menella pressed for legislation against the marriage of phthisical persons, since investigations proved the transmission of tuberculous toxin, and even of bacilli, by the placenta and semen.

Dr. Sanarelli read a most suggestive paper on the dangers of infection in railway carriages, etc. He especially pointed to the wagon-lits, and asked that there should be not merely a general disinfection of such vehicles, but alterations in the material and arrangement of the upholstery, so as to allow of daily cleaning. He asked for special carriages for consumptives. The model railway carriages now on review at Rome were mentioned.

Dr. Posner gave the result of 1,300 necropsies in Virchow's clinics, showing that of the tuberculous cases 30 per cent. had tuberculous disease of the genito-urinary organs.

In the therapeutic section there was little new, iodoform being the favorite remedy, administered in every possible way. Professor Cervello had been expected to demonstrate his method of inhaling formic aldehyde. A proposal to abolish vaccination because of the risk of tuberculous infection received no support.

Dr. Germano gave an interesting account of the facility with which fish, especially the carp tribe, could be rendered tuberculous by feeding them on the sputum of consumptives.

Professor Iranzo had good reason to point out that the objects of the Congress would be more surely attained by the education of the public than by the passing of resolutions urging the Government to legislate on an infinity of professional whims.— *Lancet.* — *The American Practitioner and News.*

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## THE CHARACTERISTICS OF A PLAGUE INVASION.

The characteristic of invading plague, which is at once most dangerous and almost constant, is its insidiousness. In whatever latitude the plague appears this quality of the disease is displayed. Weeks and months may pass before epidemic proportions are reached. Even where plague is familiar, the stealth of its progress, so Barker tells us, frequently betrays health officials into premature annoucements that the disease has been stamped out. In this respect the invasion of plague is to epidemic plague about as a slow-burning fuse is to a charge of dynamite. Hasty action upon the belief that the fuse has gone out is extremely dangerous.

This unperceived progress suggests to the sceptical mind the existence of very mild unrecognized cases, and there are instances among recent epidemics which support this suspicion. In Hong-Kong cases of mild adenitis were observed for some time before the first case of plague was recognized, and it is probable that the wide distribution of the infection was accomplished through these cases. Fortunately, epidemics usually begin with cases showing the typical bubo, other varieties of the disease appearing later. In this form the diagnosis is easy, and it is well within the ability of American physicians to recognize it If an outbreak should begin with pneumonic cases, the probability of correct diagnosis is small. The recent outbreak at Kolobovka in Russia was of this type, presenting twenty-four cases with twenty-three deaths, all of the pneumonic type.

The quality of insidiousness is probably due in most instances to the spread of plague by rats. Many histories of epidemics begin with a single case, or one infected house. Two or three weeks pass without any apparent spread. Then a commotion appears among the rats, dead bodies are found, and the rats disappear from the vicinity. Following this, human plague occurs, perhaps at several points distant from the original focus. Sometimes the behavior of the rats attracts no attention in the infected locality, nor is their migration observed. The earliest premonition of a plague visitation has sometimes been a notable increase in the number of rats, coming from none knows where. A recent outbreak in Bombay, and one in Calcutta, followed such a migration of rats.

Possessing routes of travel so well hidden from the eyes of men, and clinical disguises so baffling, plague may put physicians and health officers to confusion about as easily in

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our American cities as in the East. It is quite usual for those who write about plague to tell us that under the conditions of Western civilization plague will be easily controlled, and these views have a calming influence upon the popular mind. The hygienic condition of American cities and the habits of American citizens are probably not favorable to the spread of plague, but those of us who must bear the probable opprobrium of a first encounter will do well to examine whether our defenses are in fact as strong as they appear. No infected port is near enough to bring the time of transit to our shores within an incubation period of plague, and it is therefore unlikely that an unrecognized case in man will pass quarantine. But plague infected rats on board ship might escape observation. The rules of the United States Marine Hospital Service do not require the examination of cargo for the bodies of dead rodents. This suggestion was made by the Oporto Plague Commission, and affords one more safeguard along that most obscure route of invasion.—*Maryland Medical Journal.*

## TREATMENT OF SYPHILIS IN GENERAL AND OF TABES POST-SYPHILITICA IN PARTICULAR.

BY H. TSCHIRIEFF.

Seventeen years' experience in the neurologic service of the military hospitals at St. Petersburg and at Kieff has convinced Tschirieff that syphilis is a constitutional disease and is never completely cured, and that iodide given with the mercury prevents the absorption of the latter. He describes tests which confirm this prevention of absorption of mercury by the iodide, and explains the more frequent recurrences of syphilis, and especially of syphilitic affections of the central nervous system, when iodide was combined with the mercury. The method he recommends is a daily bath at 35° C., twenty to thirty minutes in length. Half an hour to an hour after the bath the inunction is made, for which he prefers mercurial soap, as it requires less time than the ointment. The back and sides he considers best adapted for the inunctions, which are made for six days, then omitted the seventh, repeated for five to six weeks; the mouth rinsed with saturated solution of potassium chlorate seven to eight times a day. After five or six weeks of inunction and an interval of one or two weeks, a daily bath at 35° C. is taken three times a week and .5 to 4 gm. of a preparation of iodin three times a day, after meals in a glass of milk or milk and Seltzers' water.

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Sleep is regulated with bromides and the heart supervised. This method of treatment requires three months and, usually gives remarkably fine results, not injuring the organism in any way, but actually raising the general tone and increasing the weight. One of his patients is a man of sixty, who for forty years has taken a hot bath every day and makes several inunctions every week, and his health is as perfect as is possible for a man of his years. The causes of the frequent affections of the central nervous system are inadequate treatment of the syphilis, abusus spirituosorum, excesses of all kinds, including intellectual work, and frequent chilling of the body, especially the lower extremities, from climatic conditions. He treats post-syphilitic tabes with specific treatment, Charcot douches to the back, electrization of the spine and medulla oblongata, cauterization of the spine with the Paquelin every tenth to fourteenth day, strychine pills to restore the function to the centers of erection and defecation, and subcutaneous injections of atropine and morphine for the lancinating pains. This treatment arrests and may possibly cure the sclerosis of the posterior columns of the spinal cord, which he considers the specific lesion of post-syphilitic tabes. Every case thus treated showed marked improvement.—*Dermatologisches Zeitschrift (Berlin)* - *The American Practitioner and News.*

## MONOGAMY AND LONGEVITY.

In the *Lancet* (London), of June 9, Dr. Harry Campbell F. R. C. P.' Lond., contributes an article on the increase in the death rate from cancer, in the course of which he discusses monogamy in its relation to longevity and the diseases of late life. The author says :

"The increase in the death rate from cancer has of late attracted, and rightly attracted, the attention of medical men, and various opinions have been advanced to account for it. One reason doubtless is that, owing to the increased average length of life, more people live into the cancerous age now than formerly. Some hold this to be the entire explanation, and doubt if there has been any increase in the individual tendency to the disease. I believe, however, that I can see no reason why the individual tendency should increase, and though the suggestion I have to offer may at first sight appear chimerical, I yet hope to advance a convincing argument in its support. My contention is that monogamy tends to favor the increase in our race of all late-life diseases, cancer among them, and to shorten the vital span. * * * While, however, monogamy is thus exer-

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cising an injurious influence on our race, polygamy is a sociological impossibility, and happily we have at our disposal a much more efficacious means than is afforded by it of securing to the fittest the largest number of offspring—of giving full play to that searching process of elimination which alone can sustain a high level of racial fitness. Nature's method of elimination is a merciless one; she unceremoniously sacrifices the individual for the benefit of the race—so careful of the type is she, so careless of the single life. The sole object of individual elimination, racially considered, is to prevent the unfit individual from leaving offspring to inherit his unfitness, and Nature in her rough-and ready way achieves this object by simply wiping him out of existence. The same end can be attained, however, by the unfit abstaining from getting unfit offspring and choosing to join the ever-increasing army of the non-marrying. Elimination from the racial standpoint means not having offspring, and all who do not leave offspring are racially eliminated—unrepresented in posterity."

## INJECTIONS OF ETHER IN SEBACEOUS CYSTS.

Emile Sergent, in *La Presse Médicale* of June 30, 1900, has an interesting article on the treatment of sebaceous cysts by injection. The proceeding was first employed by Vidal in 1853, and was practiced extensively by Lermoyez. Sergent has treated about thirty cases, all of which were radically cured. The manner in which the injection acts has been variously explained. By some it has been thought to be due to an inflammation excited in the wall of the sac, and by others to the power which ether has of dissolving the sebaceous matter contained in these cysts. The writer is of the opinion that the latter explanation is correct, for he says that inflammation is an accidental concomitant due to a failure in aseptic technique. It is possible to treat cysts of all sizes in this way, but those which are small, composed mostly of fibrous tissue with very little sebaceous matter, are not likely to be benefited. The method is inapplicable to cysts that have already undergone inflammatory changes.

Pure sulphuric ether is employed, and the usual operative aseptic procedures are used. A hollow needle connected with a sterilized syringe is thrust directly into the cyst. The cyst is then distended with ether, the needle being allowed to remain in position. The ether immediately dissolves the sebaceous contents of the cyst, and some of it escapes. Then more ether is introduced. The number of injections required

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will depend upon the size of the cyst and the condition of its walls; commonly from four to twelve are necessary. When the cyst is much softened or fluctuation is apparent, and a brownish crust appears at the margin of the point where the needle is thrust into the sac, the contents may then be readily expressed by opening up the tract with a stylet. If this cannot be done, an additional injection or two may be given. After the contents of the sac have been evacuated, it is possible to remove the sac through a comparatively sma lopening. It is claimed that this is the best treatment for cysts of medium size. It is not painful, no blood is lost, there is no danger, and no cicatrices are left. The latter the writer regards is of especial importance, as he says there is really little to choose between a head which is covered with wens and one which is covered with scars left by their removal.

## THE ABORTIVE TREATMENT OF BUBO.

H. M. Christian, in the *Therapeutic Gazette* of August 15, 1900, says that highly satisfactory results have been obtained by the abortive treatment of bubo. Successful application of the method depends upon its being instituted early, before suppuration has set in. Another condition is that it shall be due to gonorrhea, chancroid, or herpes, as tubercular infiltration of the gland is not influenced by the treatment. The treatment recommended by the writer consists in the direct application of the following ointment:

℞ Ung. hydrarg.....
Ung. belladonnæ.....
Ichthyol.....
Lanolin.....āā ʒ ij.

The ointment is spread upon a piece of surgical lint, and applied directly to the swollen gland. Cotton is next laid over the gland, and the whole is held in its place by a spica bandage, with firm pressure. This treatment is carried out every day until resolution takes place, which is usually accomplished in from ten days to two weeks. Twenty buboes have been treated in this manner, of which twelve were successfully aborted. Eight of the cases followed gonorrhea and four chancroid. Of the eight cases where the abortive treatment failed, six were cases of tubercular adenitis. The result of this treatment has convinced the writer that fully 50 per cent. of buboes other than tubercular can be successfully aborted by this treatment, provided only that it be employed before the formation of pus.

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# SURGERY.

IN CHARGE OF

ROLLO CAMPBELL, M.D.,

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AND

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## PEROXIDE OF HYDROGEN IN HIRSUTIES.

Dr. L. Duncan Bulkeley (*Jour A. M. A.*) says that the *bleaching* properties of peroxide have long been used for changing the color of the hair, and advantage may be taken of this in connection with the growth of superfluous hair on the face of women. In a very considerable number of cases he has employed it. where the hair was too fine to admit of removal by electrolysis, and yet where it was very perceptible and troublesome. Especially on the upper lips of girls, this condition is often the source of much distress. Here the slight downy mustache will be composed of innumerable fine hairs, perhaps with a few stronger ones at the ends, and it is quite impracticable in the early stages to practice electrolysis. Here the free and repeated use of the peroxide will produce a very material improvement in the appearance in a very short time. By blanching the hairs a moustache which was very striking will hardly be noticeable at a short distance. But another advantage in the use of the peroxide in hirsuties is a certain retarding influence which it exerts on the growth of the hair. This he has noticed in a number of instances for the past two or three years, much to the delight of some patients. In applying the peroxide to such cases it is often well to begin by diluting it one-half with water, and increasing the strength gradually. for when a strong specimen is applied to the healthy skin it will sometimes cause a desquamation which is extremely unpleasant to the patient.—*Indiana Lancet.*

## THE DIAGNOSIS OF TUBERCULAR DISEASE OF BONE.

Acute tuberculosis of bone is comparatively rare. It usually occurs in the course of a general milliary tuberculosis, or as a secondary infection of the diaphysis of the long

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bone from an epiphyseal focus. In these cased the diagnosis is usually easy.

By far the most common form of the disease which we meet with is the chronic tubercular osteomyleitis. In fact, about 95 per cent. of the chronic affections of bone may be classified under this head. It is essentially a disease of early life, as most tubercular affections are. It is safe to say that almost all affections of the long bones, especially when located in the epiphyses, and occuring in early life, are tubercular. If abscess is present the diagnosis is positive, for there is only one other condition which might produce it, —actinomycosis.

The family history in these cases is frequently tubercular, and should always be inquired into in every case of bone disease.

The subjective symptoms are: 1. Pain. This is present in all degrees of severity, from a mere tired, uncomfortable feeling, following prolonged use of limb, to the severe excruciating pain resulting from the destruction of the subarticular layer of bone, and involvment of the joint. In children, restlessness, and the so called "night-cries" frequently occur. As a rule, however, especially in the early stages, the pain is not severe, the function of the limb not being markedly interfered with, the only discomfort being an "aching" or disinclination to use the limb. With the infection of the periosteum and formation of granulation tissue, resulting later in abcess, the amount of pain is much increased, or if the joint become involved, it usually becomes severe. The pain in the early stages is very often referred, as instanced by pain in the knee-joint, in diseases of the neck or head of the femur.

2. Tenderness. This symptom Dr. Senn considers of great diagnostic importance, especially in the early stages. He says: "existence of an area of tenderness over a point corresponding to a tubercular focus in the interior of a bone is one of the surest indications of the existence of osteotuberculosis." This symptom can be elicited by pressure with the thumb or finger over the epiphysis of the bone. It is due to the presence of a circumscribed periostitis, situated above the tubercular focus.

3. Loss of function. This symptom should be considered under the head of tubercular arthritis, as it is unimportant in the early stage of tubercular osteitis.

The objective symptoms are:

1. Atrophy. This is usually present early, though in a slight degree, and is probably due to reflex causes. Vulpian.

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was the first to bring forward the theory that the atrophy is due to irritation of the terminal filiments of the articular nerves, which is reflected the centers of the muscular nerves. That in some cases the atrophy is direct is shown by its resulting from a neuritis involving both the articular and muscular branches of the same nerve, and from the fact that the atrophy is more or less permanent, even after the tubercular process has been cured.

2. Swelling. This symptom is usually not present in the early stage, and does not occur until the joint or periosteum becomes affected. There is usually no enlargement of the bone itself in cases of tubercular osteomyelitis, except in the condition known as spina ventosa, or in an extensive diaphyseal infection of the bone.

3. Changes in the color of the skin. With the occurrence of much swelling, the skin becomes very pale and is traversed by large blue veins. In the latter stages, when abscess formation occurs and the skin becomes involved, it has a purple or livid hue.

4. Abscess. Sooner or later, unless resolution occurs, the products of the inflammation undergo caseation and liquifaction, resulting in the formation of an abscess, which, sooner or later, finds its way into the joint or through the periosteum, burrowing in the direction of the last resistance until it opens through the skin, resulting in the formation of one or more sinuses. This is known as a cold abscess. It is usually slow in forming, and the symptoms of inflammation are not marked, whereas in those cases in which there is a mixed infection the local and constitutional signs are distinct.

5. Sequestration. As a result of the inflammation and disturbance of circulation, the formation of sequestra of greater or less size takes place. This can be demonstrated by the probe, or when of small size they are frequently seen in the discharge, which is of a peculiar, thin sanious character.

6. Rise of temperature. By carefully taking the temperature at frequent intervals, a rise of only perhaps one-half degree may be detected, especially towards evening, and is decidedly significant of tubercular trouble.

7. Anemia, emaciation, asthenia and hectic are not usually marked until we get a mixed infection. Then these symptoms become very pronounced.—Dr. Chas, G. Foote, in *Cleveland Medical Gazette.*

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## LARGE TRACT OF CHRONIC BURN ULCERATION HEALED BY SKIN-PROPAGATION IN BLOOD, FROM MINUTE POINTS OF DERMAL TISSUE

By T. J. BIGGS, M.D., Stamford, Conn.

Mary C——, aged 22, came on the 7th of February, 1895, to the surgical ward of Demilt Dispensary, showing a tract of four or five square inches on the right side of her face completely denuded of the skin and superficial fascia, in consequence of a burn which had been unsuccessfully treated by the usual methods in vogue at two of the city hospitals. The wound extended over the right malar bone, from a point just below the margin of the lower eyelid, downward and sideways over the nose and cheek, a distance of three inches, with an inferior diameter of an inch and a half. The sore was now covered with unhealthy granulations, and exuded smelling mucopurulent discharge. After cleansing the wound with Thiersch solution, its entire surface was cauterised with a 25 per cent. etheral solution of pyrozone, and was dressed for three days with wet Thiersch dressing, until healthy granulation became established.

Ten minute points of skin, about one-sixth of an inch in diameter (shrinking to half that size) were then taken from over the right scapula, and distributed in an elliptical line. about half an inch within the periphery of the wound, leaving a like distance between the opposite sides of the elliptical line. These were protected with strips of sterilized rubber tissue, which does not adhere to the grafts so as to displace them when it is removed. The dressing was of gauze soaked in salt and water, i dr. of salt to the pint, which is found to be the application most favorable for the setting of the grafts. Over this, more rubber tissue, cotton and a bandage.

The dressing was removed on the third day, when every graft was found feebly adherent, and the general surface in a healthy condition. After cleansing with Thiersch solution, fresh rubber tissue was applied, and the dressing was now made of plain sterilized gauze soaked with bovinine, and covered with oiled muslin, cotton and bandage. On removing this dressing on the second day, the wound was found in a healthy granulating condition, with every graft firmly adherent and healthy in color. The blood dressing was repeated in the same manner every day for a week, when all the grafts were found to be doubled in diameter and in a promising condition, which continued healthy granulation. Thenceforth, sterilized gauze soaked with bovinine, and nothing else, was applied directly and daily to the surface

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treated, for seventeen days, to March 9th, making thirty-one days in all from the first appearance of the patient at the dispensary, when the whole diseased tract was found to be perfectly healed and covered with new delicate skin. Dressing was discontinued and patient instructed to wash the part four or five times a day with sterilized water, reporting for observation, and after three days was fully discharged.

## PERITYPHLITIS, CASE DESPERATE, BLOOD CURED WITHOUT OPERATION.

By T. J. BIGGS, M.D., Stamford, Conn.

Ellen F——, 27 years of age, American, admitted June 5th. Diagnosis: Perityphlitis.

Case had been brought to the hospital by Dr. B—, with a request that I operate immediately. So severe was the condition that I agreed with the Doctor that a laparotomy was advisable. This, however, the patient refused to have done, saying she preferred to die. Consequently, after assuring the patient of an unfavorable prognosis, I determined to do the next best thing.

The condition began two days previous with a feeling of weight, soreness and paroxysms of acute pain extending into the hip, thigh and abdomen. Examination of her after entering the hospital revealed a hard swelling in the right iliac fossa region. The patient had a temperature of 102½, had irregular chills, followed by profuse sweats. The bowels were regular. In my mind two things were immediately indicated here:

1. That the digestive tract be given as near as possible absolute rest.

2. To try to reduce the inflammatory process. This I knew could be combated by bovinine.

The patient was put to bed, an ice pack put over the vascum and a teaspoonful of bovinine given every hour. For the first three days the patient showed no improvement, but held her own fairly well. On the fourth day she said the feeling of weight and soreness in right side was less, and she had fewer paroxysms of pain which were, by the way, confined to the right side. The temperature was now 101. Bovinine was now ordered a tablespoonful every two hours in sterilized milk, and once every three hours a teaspoonful of bovinine-Thiersch was given.

June 14th, the swelling and pain had entirely disappeared, temperature normal, and although well nourished was

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pretty weak. Bovinine was now ordered a wine glassful every three hours in milk.

On the 20th the patient was feeling well and strong. Bovinine continued.

On the 27th she was discharged, cured.

The action of the bovinine in this condition is threefold:

1. It requires little or no digestion, and at the same time, supplying perfect nutrition, gives the alimentary canal almost absolute rest, as no form of food will do.

2. It being a sterile preparation, acts as an antiseptic, which is exactly indicated in this condition.

3. It builds up and restores to normal the degenerated mucous membrane, by its nutritive power, and at the same time acts as an antiphlegistic.

## NOTES ON THE ENEMATA EMPLOYED AFTER ABDOMINAL SECTIONS.

For the thirst which is sometimes so distressing after an abdominal section, an enema consisting of 500 cc. (one pint) of tepid water may be slowly administered, being repeated if necessary.

Nutritive enemata are often employed at intervals of three or four hours. They should not be given more frequently than this for fear of rendering the rectum intolerant of them. The enemata should consist of milk with whisky or brandy, together with white of egg and a little common table salt. The following proportions make a good combination and may be given by means of a hard rubber syringe or through a rectal tube:

℞ Peptonized milk, 30 cc. (℥i)
Whisky, 30 cc. (℥i)
The whites of two eggs
Common table salt, 1.5 (grs. xxiv)

The rectum should be thoroughly irrigated every morning with warm physiological salt solution, which will keep it clean, so that the nutritive enemata will be better absorbed.

For opening the bowels a high enema consisting of 500 cc. (one pint) of soap-suds in warm water should be given. The rectal tube having been introduced well up into the rectum, the mixture of soap-suds and water is poured into a glass funnel attached to the external end and allowed to run slowly into the bowel. Sometimes a litre can be introduced

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in this way. If the enema does not prove effectual, it may be repeated after three or four hours, or we may substitute one consisting of warm water, oil, turpentine, in the following proportions:

℞ Plain warm water, 500 cc. (℥j)
Olive oil, 60 cc. (℥ij)
Turpentine, from two teaspoonfuls to a tablespoonful.

This may be repeated once or twice at intervals of two or three hours, but generally the first enema is followed by a satisfactory evacuation of the bowels. If preferred, from 120 to 180 cc. (4 to 6 oz.) of warm olive oil or glycerine may be first injected in order to soften any fecal matter that is in the rectum, an enema of soap-suds and warm water being given an hour or so later. Occasionally the addition of an ounce of Epsom salts to a pint of warm soap-suds and water will prove effectual when other enemata have failed.

In a series of 114 consecutive, unselected, abdominal sections without a death one or more of the above enemata were employed as a routine practice.—Dr. Hunter Robb, *Cleveland Medical Gazette.*

## HEROIC TREATMENT FOR SOFT CORNS BETWEEN THE TOES.

Physicians should be more fully informed upon disturbances of the feet. Too often they brush aside these complaints and leave the victims to their own awkwardness or the tender mercies of itinerant and often ignorant chiropodists. We should realize that, owing to neglect of proper cleanliness, the feet may become potent dangers in the direction of general infection where self treated or improperly handled by others.

In discussing recently, at the New York Post-Graduate Medical College, the subject of soft corns, Dr. A. M. Phelps, the eminent orthopedic surgeon, said:

"We all frequently meet with cases of soft corn, occurring particularly in the working classes, between the toes. They are extremely painful, crippling the patient and rendering life almost unendurable. These cases come to the hospital and ask to have the toes amputated. Such corns are usually treated conservatively, and are cured, but immediately relapse. Deep sluffing ulcers are frequently seen.

"A simple procedure which I have followed many times during the past two years answers admirably and saves the toe. It consists in removing all of the soft tissues on the inner

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side of two of the toes, removing the corn, and stitching the two toes together. This procedure does not in the least impair the usefulness of the foot, whereas, the removal of the toe must necessarily do so to a certain extent.

"Patients upon whom I have operated in this manner have expressed themselves as entirely satisfied, and I am certain that if I had a soft corn that caused me much trouble I would have no hesitancy in having the operation performed, and the toes 'webbed.' The nail of the little toe should be removed."—*Gaillard's Med. Jour.*

## ANKLE SPRAINS.

Sprains are by far the most common joint injuries, and of all the joints of the body the ankle is the one most frequently involved; in fact, ankle sprains are probably as numerous as all other sprains combined.

If one looks through the literature on this subject, one cannot help but be impressed with the chaos that exists on so simple a subject as the treatment of ankle sprains A considerable number of text-books and teachers state in unmistakable terms that the only proper treatment for ankle sprains is a plaster-of-Paris cast, applied directly after the injury, and worn some weeks. Another almost equally large and authoritative number state with equal emphasis that the only satisfactory treatment consists in subjecting the sprained ankle to active and passive motion and massage directly after the injury. A minority recommend cold or hot applications with elevation of the limb and firm bandages; later, plaster-of-Paris cast, and, finally, massage and active and passive motion.

After thinking the matter over, it seemed strange to me that any one would care to confine himself so rigidly to either of the first two methods, as some of the authors would have one believe that they do. Of the three general methods outlined, the third certainly commends itself most highly to one's common sense, and it is the one that I would adopt were it not for the fact that I have seen a method demonstrated which is far superior to it in its results.

The method which I wish to describe comprises practically all of the good features of the three, without any of the objectionable ones. It consists in careful and systematic strapping with rubber adhesive straps. The straps are cut from half to three-quarters of an inch in width, and the proper length. The width depends upon the size of the limb. If a small ankle, the straps should

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be half an inch wide; if a large ankle, they may be three-quarters of an inch, but no wider. Upon this, and upon the accuracy with which they are applied, depends the success of the method. If the straps are too wide, or if they are applied in a haphazard manner, failure is sure to be the result.

The foot is held at slightly less than a right angle and a trifle everted. The former element in the position is observed because it is easier to walk on a painful ankle if it is held slightly in the calcaneum position than if held in the equinus position. The latter element is observed because, as you well know, ankle sprains are usually caused by a sudden inversion of the foot, thus injuring the external ligaments; hence, slightly everting the foot relieves the tension of these ligaments and places them at rest. With the foot in this position, one end of a long strap is applied to the inner surface of the foot near its posterior end, brought under the heel and up on the outer posterior surface of the leg to within a few inches of the knee. At the lower end this falls into the depression just posterior to the external malleolus. A shorter strap is now applied by placing one end to the inner surface of the heel near the sole of the foot, then bringing it around over the tendo Achilles to the outer surface of the foot, making it cover the first strap at a right angle and passing along parallel to the under border of the sole of the foot, then over the dorsum to the little toe. Another long one is now applied, anterior to the first, overlapping it about one-third of its width; then a short one, and so on, alternately, until the outer anterior aspect of the ankle is reached. Over all this a hard rolled bandage is now carefully and snugly applied. The patient is directed to lie still with the foot elevated until the warmth of the body has caused the plaster to adhere firmly. In a great majority of instances the patient can walk, with reasonable comfort, after a few hours.

The question that all who have not tried this treatment are prone to ask is, "How is it possible that so simple an appliance, or dressing, can give such excellent results?" I can answer this only in part. Where it is applied before the swelling has taken place, it prevents, or at least limits, the effusion of blood and serum into the joint and surrounding tissues. It partly immobilizes the joint, and supplants, in a measure, the lacerated ligaments. It relaxes the muscles and gives the joint a feeling of security.

In older sprains, it supplies the very best kind of massage possible. The massage which a joint gets by the

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unconscious or subconscious motion under a dressing which exerts uniform pressure, besides being much cheaper and more accessible to all, is infinitely better than the massage which the most experienced masseur can give. This constant massage and motion rapidly dissipates the swelling by causing absorption of the effusion. It quickly and surely relieves the pain. It overcomes the tendency to stiffness. It restores the muscles and ligaments to their original vigor and strength. It reduces the period of treatment from weeks to days. It does all this, while the limb may be used with reasonable comfort and perfect safety from the day the bandage is applied.—*Dr. E. H. Ochsner, in the Virginia Medical Semi-Monthly.*

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# Therapeutic Notes.

### Hepatic Troubles.

℞ Phosphate of soda..... 1 drachm
Chionia..... 8 ounces

M. Sig. A dessertspoonful three times a day.

### Sore or Cracked Nipples.

℞ Castor oil..... 1 drachm
Subnitrate of bismuth..... 1 drachm

This is applied freely to the sore nipples.—*Hirst, Med. Rec.*

### To Check Milk Secretion.

℞ Atropinæ sulphat..... $\frac{1}{30}$ grain
Magnes. sulphat..... 2½ ounces
Infus. gentianæ..... 7 ounces

M. Sig. Tablespoonful every two hours.—*Gaz. Hebdomad.*

### Pigment Spots of Pregnancy.

℞ Zinc oxide..... 1 drachm
White precipitate..... 1½ grains
Castor oil..... 2 drachms
Ess. of rose..... 10 drops
Cacao butter..... 2 drachms

M. Sig. Apply morning and evening.—*Ex.*

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### For Inflamed Rheumatic Joints.

Osler recommends Fuller's lotion:

| | | |
|---|---|---|
| ℞ | Sodii carbonat..... | 6 drachms |
| | Tincturæ opii..... | 1 ounce |
| | Glycerini ..... | 2 ounces |
| | Aquæ ..... | 9 ounces |

M. Sig. Saturate hot cloths with the lotion and apply to the parts.—*West. Med. News.*

### Remedy for Rigid Perineum.

Dr. Southworth says the following he considers indispensable and infallible:

| | | |
|---|---|---|
| ℞ | Chloroform ..... | 2 drachms |
| | Ether..... | 1 drachm |
| | Cologne spirits..... | 1 drachm |

M. Sig. Apply locally.

He further says he has had large heads pass perineums which seemed impossible without extensive rupture, without even the beginning of a tear, when this preparation was used.—*Medical Times.*

### For Delayed Resolution in Pneumonia.

Small blisters over affected areas, and

| | | |
|---|---|---|
| ℞ | Potassii iodidi..... | 1 drachm |
| | Ammonii chloridi..... | 1½ drachms |
| | Misturæ glycyrrhizæ comp.. | 6 ounces |

M. Sig. Tablespoonful four times a day.—*De Costa, Texas Medical News.*

### Palatable Effervescing Quinine.

| | | |
|---|---|---|
| ℞ | Quininæ sulphatis..... | ʒj |
| | Acidi citrici..... | ʒijss |
| | Syrupi simplicis..... } | āā ʒxv |
| | Syrupi aurantii cort..... } | |
| | Aquæ destillatæ.....q. s. ad. | ʒvj |

M. Sig. Add 10 or more drops to about two ounces of water, in which gr. v. of bicarbonate sodium has previously been dissolved, and drink while effervescing.—*The Practitioner.*

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# Jottings.

## Salt Withheld in Epilepsy.

Richet and Toulouse announced, at a recent meeting of the Paris Academy of Sciences, that their experience with 30 female epileptics has demonstrated the fact that depriving the nervous system of the usual amount of salt in the blood renders the nervous tissue more susceptible to the absorption of medicinal salts, which it takes up to a remarkable extent, thus rendering an extremely small dose effective. Thus 2 grams of sodium bromide a day, administered under the conditions referred to, arrested the epileptic attacks, sometimes in less than a week, no matter how frequent they had been before. Several patients had shown no recurrence for six months since treatment. Richet proposes to call this the metatrophic method, and suggests that it may possibly apply also to affections treated with quinine, digitalis, atropine, etc., as well as those in which the alkaline salts are administered. The saltless food has no bad effect on the patient.—*Exc.*

## Ice for Nausea.

A physician advances the theory that the distressing sensation of nausea has its seat in the brain and not in the stomach, and that relief may be obtained by cooling the base of the brain. He claims to have tested this often and thoroughly in the case of sick headache, bilious colic, cholera morbus, and other ills in which the nausea is a distressing symptom without a single failure; also, that he once relieved the nausea resulting from cancer of the stomach by the application of ice to the back of the neck and occipital bone. The ice is to be broken and the bits placed between the folds of a towel. Relief may be obtained by holding the head over a sink, or tub, and pouring a small stream of water on the neck. This is worth remembering, as a relief for sick headache, to which so may are subject.—*Exc.*

## Urticaria.

The agent to which I desire to call attention in this article is carbonate of potassium. Simple carbonate of potash —kali carbonicum. It is the remedy of all others for that common affection, hives, or, more specifically, urticaria.

The prescription is simple: Add ten or fifteen grains of

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kali carbonicum to half a pint of water, and order a teaspoonful every hour until relief follows. Three or four doses a day for a day or two afterward may be required to confirm the cure. The size of the dose does not matter so much, so it is small enough to insure immunity from unpleasant drug action, and large enough to produce slight therapeutic effect. —*Amer. Med. Jour.*

Fifteen to twenty grains of camphoric acid will, as a rule, stop night sweats, especially of phthisis, better than does any other drug, it being free from all the objections against atropia or belladonna, and may be given even in larger doses.—*Med. Council.*

## Minute Doses of Conium.

Conium acts as well upon the urinary organs as upon the reproductive. In feeble people, with frequent drippling urination, especially at night, with burning, cutting urethral pain, a turbid, thick, whitish or bloody urine, and a sense of weight or pressure about the bladder, it is the remedy that will satisfy patient and physician.—*Ec. Med. Journal.*

## A Cough Mixture.

Dr. L. M. Taylor (Merck's *Archives*, August) has used the following prescription with most satisfactory general results:

℞ Chloral hydrate..... 64 grains
Ammonium carbonate..... 32 "
Fluid extract of ipecac.. ... 1 fluid drachm
Spirits of nitrous ether (Squibb)..... 2 fluid drachms
Syrup of tar,
Syrup of wild cherry,
Syrup of tolu,
Camphorated tincture of opium, } of each, 1 fluid ounce.

Shake well and take a teaspoonful when the cough is troublesome.

## Incontinence of Urine.

According to the *Buffalo Medical Journal*, lycopodium has been used with success for this affection in children.

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Twenty drops of the tincture should be given three times a day, and this dose may be increased to 40 or 50 drops. It is, in some cases, more efficient than belladonna.

### To Keep the Hands Soft and White.

In these days of asepsis the hands of the physician, and especially of the surgeon, suffer greatly from frequent scrubbings and immersions in antiseptic solutions. A preparation that will keep the hands soft and white and that will not at the same time be inelegant to use is always in demand. The following formula will be found to be one of the very best ever proposed for the purpose:

℞ Ol. rosæ, 15 drops.
Glycerin, 1 drachm.
Spt. of myrciæ, 3 drachms.
Ol. cajuput., 20 drops.

M. Apply at night before retiring, first washing the hands thoroughly in hot water. In cold weather this can also be applied to the hands before going out.—*California Medical Journal.*

### Chronic Eczema.

A confrère asserts that he obtains the radical cure of eczema where it occurs in isolated patches on the upper extremities, and so rebellious to the ordinary method of treatment, as follows: After having washed thoroughly with soap and water the part and dried it, he rubs in vigorously a 50-per-cent. solution of caustic potash by means of a plug of cotton tied to a rod; he then washes the spot freely with water, and, finally, paints it over with a 50-per-cent. solution of nitrate of silver, and envelops the whole in aseptic cotton. This dressing is left in place until the cicatrix is formed beneath the slough, or from one to two weeks. The itching ceases immediately after the application of the caustics. Out of thirty cases thus treated, only one required the operation a second time.—*Med. Press and Circular.*

### Nocturnal Emissions.

Gould & Pyle thus sum up the treatment of nocturnal emissions.— "Too frequent emissions reduce the strength, make the patient irritable and weak, and gradually prey upon the mind. Nocturnal emissions occurring in normal males who are continent and chaste are not to be interfered with unless excessive. Unchaste literature and lascivious

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thoughts are to be avoided. A nard mattress and light coverings are advisable. Avoid sleeping on the back. Tie a spool on the loins, so that if the sleeper roll upon the back he will be awakened by the pressure. Potassium bromid, 20 grains, or the same amount of chloral may be taken on retiring. Cold sponging of the perineum and loins night and morning has been of great benefit. Potass. citrate, 20 grains in water, three times a day, will render the urine unirritating and alkalin and allay a provocative cause of emissions. Arsenic alone, or in combination with strychnine, is often of service when given in full dose. Stimulating foods and drinks are to be avoided.

## THE CONTAGIOUSNESS OF PULMONARY CONSUMPTION.

(Shurly, *Phy. and Surgeon*, Dec., 1899). Tuberculosis is considered by many observers to be contagious. The author thinks that, although the tubercle bacillus is an important factor in a large majority of cases of pulmonary consumption, other organisms, such as the streptococcus, staphylococcus and pneumococcus may play the greatest part in most cases, and that a predisposition to the disease must exist. Although the disease may be transmitted by the inhalation of dried sputum to animals which have a tendency for it and are in an unhealthy condition, the attempt often fails in those in good health and the best sanitary environment. There is not an instance based upon unmistakable evidence of a case of human pulmonary tuberculosis having originated, under ordinary natural circumstances from the inhalation of dried sputum in the air. The existence of a hereditary tendency to the disease is a very important factor. Until we have more unmistakable evidence we cannot formulate a principle upon which to decide whether consumption is contagious in the ordinary sense of the term, and, until this has been shown, we have no right to deprive patients of their natural rights.

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THE
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# Editorial.

## ANNUAL DINNER OF BISHOP'S MEDICAL AND DENTAL COLLEGE.

The Thirtieth Anniversary of the formation of the Medical Faculty of Bishop's College was celebrated by the Faculty, graduates and students by a Dinner on the 8th of November, at the Place Viger Hotel. The Dental College of the Province of Quebec, with its students, affiliated with Bishop's College, participated in the celebration. Over one hundred and twenty persons sat down to as fine a bill of fare as the Hotel could produce. Mr. E. A. Tomkins, Medicine '01, occupied the chair, supported on his right by Chancellor Heneker, Principal Whitney, Dr. McConnell, Vice-Dean L. H. Davidson, Q.C., Rev. Dr. Abbott Smith and the Rev. Dr. Ker. On his left sat Dr. F. W. Campbell, Dean of the Faculty, Dr. Wolford Nelson, of New York (a member of Bishop's first Medical graduating class), R. Wilson-Smith and C. F. Smith, Esq., President of the Western Hospital. The Vice-chairs were occupied by B. A. Planche, B.A., Dental '01, and I. A. Gillespie, L. Ph., Med. 01. A few of the graduates, who resided near Montreal, showed their continued interest in their Alma Mater by being present. Especial mention, however, must be made of Dr. Nelson, who came from New York especially for this Dinner, also of Dr. H. B. Chandler, the well-known eye

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specialist, of Boston (M.D. Bishop's, 1880), who, having purchased a ticket, asked that his chair be kept vacant, if not there to fill it, for he would be with them in spirit. The speaking was of a high order; the address by the new Principal of the University, Rev. Mr. Whitney, was most noteworthy. He held his audience captive for fully half an hour, with his beautifully constructed English sentences. The University has in him a strong man for a most important post. Chancellor Heneker and Mr. Leo. H. Davidson spoke eloquently. Dr. Wolfred Nelson spoke in response to "Alma Mater," and noted the good work Bishop's sons were doing in the United States. Mr. R. Wilson Smith, in replying to the toast of our guests, said that he knew the great work which Bishop's Faculty of Medicine was doing, and he believed that they were on the eve of this work being recognized. Once the turn was made, all who had labored so nobly would receive their reward. Mr. C. F. Smith, as President of the Western Hospital, spoke of the good work that Hospital was doing, but felt that the present building was unsuited for its work. He felt sure that, just as soon as the public knew what that Hospital was doing, it would be surrounded by friends who would rally to its support. With their assistance he hoped ere long to have erected a new building on the Hospital property, which he believed to be one of the best sites for an hospital in Montreal. This building he hoped would contain fifty private wards. With speech, song and story, the hours flew quickly past, and, as God Save the Queen was started, one could hardly realize that the clock had already struck the hour of two. Principal Whitney remained to the last.

## A PERFECT CURE FOR TYPHOID FEVER.

A late number of the *Dublin Medical Press and Circular* says:—According to Dr. Virgil Hubbard, of Atlanta, U.S.A., a treatment has been discovered by him under which typhoid fever ceases to have any mortality. Undeterred by the ridicule with which his proposals and statements were greeted at last year's meeting of the Medical Association of Georgia,

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he again comes forward to insist on the unvarying success of his method. As the New York *Medical News* has thought the paper worthy of reproduction in full, we may mention that the treatment in question consists in giving the patient a capsule containing half a grain of calomel, two grains of carbonate of guaiacol, and from a twentieth to a fortieth of a grain of podophyllin, every two hours, for the first 24 or 48 hours. After four or five intestinal evacuations he stops the calomel and substitutes half a grain of menthol. This comprises what the author calls the antiseptic and eliminative treatment of typhoid fever. Should the bowels tend to become inactive he gives small doses of Hunyadi Janos water, and, if the temperature remains high after four or five days of treatment, calomel is again resorted to. In addition to this he frequently resorts to the administration of normal saline solution, *per rectum*, especially in cases where the skin and kidneys fail to act well. Unfortunately, the author does not give us any statistics to go by, but, after all, the real test of a treatment—we hesitate to call it a *new* treatment because the antiseptic treatment of typhoid is quite old, and the choice of a particular antiseptic scarcely justifies the claim to constitute a new treatment, is the result obtained in the hands of others.

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## PERSONAL.

Sir Henry Ackland, Regius Professor of Medicine in the University of Oxford, died on the 16th of October. He was born in 1815.

Dr. John B. Murphy has accepted a Professorship in Surgery and Clinical Surgery in the Northwestern University Medical School—Chicago Medical College. Dr. Murphy has been appointed Surgeon-in-Chief of Mercy Hospital, with the direction of the surgical teaching in that Hospital.

Dr. Archibald Church has been recently appointed Professor of Nervous and Mental Diseases in Northwestern University Medical School—Chicago Medical College—and head of the Neurological Department.

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# Book Reviews.

**"Bacteriology and Surgical Technique for Nurses."** By Emily M. A. Stoney, Superintendent of the Training School for Nurses, St. Anthony's Hospital, Rock Island, Ill., Authoress of "Practical Points in Nursing," "Practical Materia Medica for Nurses," etc. Published by W. B. Saunders & Co., Philadelphia, 1900. Canadian agents, J. A. Carveth & Co., Toronto, Ont. Price, $1.25 net.

This work is rather a new departure in the way of a text-book for nurses, and may be looked on as a sign of the times. Formerly a nurse was considered equipped for nursing who spent some years in an hospital gaining practical knowledge but little theory; now a nurse not only receives lectures on anatomy, physiology, etc., and passes exams. on these subjects, but she must also read one or several text-books on the subject of nursing. The present work can be highly recommended to nurses who desire to grasp the reason why asepsis is so important and how to become and remain aseptic during operative work. It is written in a simple, easy manner so that anyone reading it can understand it. Its faults are few, perhaps the worst being the putting of Carbolic Acid at the head of the list of antiseptics. Taken altogether every nurse who desires to have a thorough knowledge of her work should possess a copy of this well-written text-book for nurses.

H. L. R.

**A Manual of Otology.** By Gorham Bacon, A. M., M.D., Professor of Otology in Cornell University Medical College, New York. With an introductory chapter by Clarence J. Blake, M.D., Professor of Otology in the Harvard Medical School, Boston. In one handsome 12mo. volume of 422 pages, with 114 engravings and 3 colored plates. Cloth $2.25 net, Lea Brothers & Co., Publishers, Philadelphia and New York.

The Manual of Otology is written in a clear and interesting manner, and, while the author treats his subject in a scientific and thorough way, he shows a conservative temper.

The pathology of the various diseases is given the prominent place it deserves. In discussing the treatment of chronic catarrhal otitis media, the operative treatment which exposes the patient to great risk, and holds out but little hope of betterment, is justly condemned. The chapters treating of mastoid disease and intracranial complications are especially good. On the whole the book is an admirable text-book for the student of Otology. That Dr. Bacon's work has been appreciated is shown by the demand for a second edition in less than two years since the publication of the first.

G. H. M.

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**Lessons on the Anatomy, Physiology and Hygiene of Infancy and Childhood for Junior Students.** By Alfred C. Cotton, A.M.,M.D. Chicago Medical Book Co.,1900.

This little volume (price $1.50) of 174 pages is neatly executed, with numerous illustrations, many of them from excellent photographs.

Throughout the book the author has essayed not so much to give a treatise on Anatomy, Physiology and Hygiene, but to compare and emphasize the points of variance as seen in the infant and adult. To be able to absorb properly the many valuable points made in anatomy, and to some extent in physiology, the student must be well trained in the anatomy and physiology of the adult. To get the full benefit of this work it should be read conjointly with the larger works on Anatomy and Embryology, and certainly would aid the student materially in his subsequent clinical work.

In the consideration of the physiology of the body temperature, many useful hints are given, which influence clinical treatment, and the general care of the child in many ways. Among them we are glad to see that the old method of reducing respiration in the newborn by means of the cold plunge bath has been discountenanced as hurtful; surely there are as useful methods without the same drain on the vitality of the tender babe. The various foods receive due attention, and finally the hygiene of later infancy is discussed. We shall look forward to the more extended work which the author hints is to come. G. F.

**A Practical Treatise on Genito Urinary and Venereal Diseases and Syphilis,** by Robert W. Taylor, A. M., M.D., Clinical Professor of Venereal Diseases at the College of Physicians and Surgeons (Columbia University), New York; Surgeon to Bellevue Hospital, and Consulting Surgeon to City (Charity) Hospital, New York. Second edition thoroughly revised, with 138 illustrations and 27 plates in colors and monoline. Lea Brothers & Co., New York and Philadelphia, 1900.

This volume is one of the most elegant which has this year been issued by medical publishers. Its entire get-up is most creditable. Its illustrations are beautifully produced and are so lifelike that the disease can be recognized by any one of ordinary experience, without reference to the foot-note. The author has produced undoubtedly an up to-date, practical and compact treatise. His aim has evidently been to avoid on the one hand tediousness, and at the same time the disappointing brevity of an epitome. He has presented a thorough, systematic description of the various subjects embraced under its title, and it is given in terse and concise language. The text is not overburdened by describing in detail as morbid entities, symptoms and conditions which form part of well-recognized abnormal states. Over-elaboration of rare and unimportant diseases has been avoided, and there is no needless

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repetition. The history and description of out-of-date operations, has evidently been avoided. Subjects are presented as the medical man encounters them in practical work. In the matter of treatment, surgical or medical, Dr. Taylor has been conservative and practical in his directions, and, while Surgery proper has received full consideration, he has recognized that its performance is but a part (and not the one aim) of the subject of general Therapeutics.

The subject of Gonorrhœa, in all its phases, is exhaustively written upon, and its treatment is full and practical. We are more than pleased to note that attention is directed to the fallacies, shortcomings and dangers in some of the views now-a-days advanced for the treatment of this disease. In fact, as regards some of them, an emphatic protest is made. No one who was in practice thirty to forty years ago, after reading this portion of the work, can but feel that the methods he then followed were deserving of the success which ensued.

Syphilis, in all its conditions and relations, has been comprehensively considered, and much care has been exercised in the presentation of a concise, practical and methodical method of treatment. F.W.C.

**Pathology and Morbid Anatomy.** By T. Henry Green, M.D., F.R.C.P., Physician and Special Lecturer on Clinical Medicine at Charing Cross Hospital, etc. New (9th) American from ninth English Edition. Revised and enlarged by H. Montague Murray, M.D., F.R.C.P., Lecturer on Pathology and Morbid Anatomy at Charing Cross Hospital; Revised for America by Walton Martin, Ph.B., M.D, of the College of Physicians and Surgeons, New York City. Handsome octavo volume of 578 pages, with 4 colored plates and 339 engravings. Cloth, $3.25 net. Lea Bros. & Co., publishers, Philadelphia and New York.

In presenting this volume to the profession the Messrs. Lea make the following statement:

"When the first edition of "Green's Pathology" appeared it at once became the favorite text-book for medical students, and since that time it has easily maintained that position both in England and America. The frequent revisions that have been called for have enabled the author and editors to keep the book fully abreast of the times, and it is hoped that this ninth edition will be found more than ever to meet all the wants of the student of medicine. The English edition has been thoroughly revised by Dr. H. Montague Murray, who has rewritten nearly half the subject matter, re-arranged the text, and added several new sections, as well as no less than one hundred and eighty new illustrations. In order to adapt the work still more fully to the needs of American students it has been carefully edited by Dr. Walton Martin, who has supplied complete chapters on Malaria and on the Blood, and has added a chapter on the preparation and staining of tissues for microscopic study."

This statement adequately describes the work in question,

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which is the ninth edition, and to trace the various issues is to read the remarkable advance that has been made in Pathology since the first appeared. Another fact revealed by this quick succession of editions is the demand for fresh information and new ways of presenting accepted views. Students are no longer content to read their Pathology from books taken down from their fathers' shelves.

"Green's Pathology" was a pioneer, and it is pleasant to see it keeping well up in the present and more strenuous race. Teachers like it, and students like it, so that the new edition is sure to be popular and useful. The plates and illustrations, of which there are 343, really do illustrate the text, which, in itself, is both full and clear.

A. M.

**A Text-book upon the Pathogenic Bacteria for Students of Medicine and Physicians.** By Joseph McFarland, M.D., Professor of Pathology in the Medico-Chirurgical College, Philadelphia, etc. Third edition. Published by W. B. Saunders & Co., Philadelphia. Price, $3.25. J. A. Carveth & Co., Toronto, Canadian Agents.

The first edition of this work was published in 1896, the second two years later, and now the third has appeared. Three editions of a book in four years by a publisher who knows the needs of the market prove its acceptance by students who, after all, are the final judges as to the usefulness of a work. Dr. McFarland's writings have been and are useful in presenting from time to time a fair and comprehensive view of the work in which he is engaged. Comparing the last with the other two editions, there are evident signs of maturity in the author's ideas and his expression of them. The outburst of poetry, for example, by "Mr. Dryden" has disappeared, though the fond dedication of the book remains. In other ways, also, the diction is improved, chiefly in the direction of simplicity and clarity. The only other instance, so far as the present reviewer remembers of a work in Pathology being adorned with versification, is Collins Warren's excellent book by the same publisher, and its insertion shows a very laudable intention.

Dr. McFarland's book has grown from 359 to 621 pages, and, as a result, many new subjects are treated and old ones receive more consideration. The most valuable chapters are those dealing in a general way with the deeper problems of Pathology, that on immunity and predisposibility being particularly good. The book is by no means elementary; indeed, it is decidedly learned and quite adequate to the needs of both students and physicians.

A. M.

**Atlas and Epitome of Gynecology.**—By Oscar Ichaeffer, privat docent of Obstetrics and Gynecology in the University of Heidelberg. Authorized translation from the second revised and enlarged German edition. Edited by Richard C. Norris, A. M., M.D., Surgeon-in-Charge, Preston Retreat, Philadelphia; Gyne-

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cologist to the Methodist Episcopal Hospital and to the Philadelphia Hospital; Consulting Gynecologist to the Southeastern Dispensary and Hospital for Women and Children; Lecturer on Clinical and Operative Obstetrics, Medical Department University of Pennsylvania, with 207 colored illustrations on 90 plates and 62 illustrations in the text. Philadelphia, W. B. Saunders & Company, 1900. Price, $3.50 nett. Canadian Agents: J. A. Carveth & Co., Toronto.

The value of this "Atlas" to medical students and to the general practitioner will be found, not only in the concise explanatory text, but in the illustrations. It occupies a position midway between the quiz compend and the more pretentious works on gynecology. The large number of illustrations and colored plates, reproducing the appearance of fresh specimens, will give the student an accurate mental picture and a knowledge of the pathologic changes induced by disease of the pelvic organs that can not be obtained from mere description. Next to the study of specimens, which for evident reasons are not available outside of large clinics, well-chosen illustrations must be utilized. The "Atlas" serves that purpose well. The text is divided into two parts. The continuous text is written from a practical standpoint; the text of the plates on the contrary contains the purely theoretic, scientific, anatomic, microscopic and chemic notes, and facts of general significance (concerning sounds, pesaries, etc.,) so that, in referring to the work, the one text will not have a disturbing influence on the other. While the text is both interesting and instructive, the plates and drawings are by far the most striking feature of the book. We have hardly ever seen them equalled, and certainly never excelled, and both author and publisher deserve the highest praise for having gone to so much trouble and expense as they evidently must have done. The careful observation of one of these plates will give one a better idea of the subject than the reading of many pages of description. The therapeutic table near the end of the book is a new departure, and one of great value. Altogether, the book is a remarkable one, and must be seen to be appreciated.

A. L. S.

**Fractures.**—By Carl Beck, M.D., Visiting Surgeon to St. Mary's Hospital and to the New York German Poliklinek, formerly Professor of Surgery, New York School of Clinical Medicine, Consulting Surgeon Sheltering Guardian Orphan Asylum, New York. Octavo, 225 pages, 170 illustrations. W. B. Saunders & Co., Philadelphia. Canadian Agents: J. A. Carveth & Co., Toronto, Price $3.50.

The author has dedicated this work to "William Conrad Roentgen, without whose work much of this book could not have been written," and this statement shows that this volume owes its existence to the increase in the understanding of fractures, which has resulted from the frequent use of the X-ray in their diagnosis.

Before Roentgen's discovery, it was, of course, not possible

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to make portraits of fractures from life; the illustrations in the older works were mainly made from the cadaver, and consequently the minute arrangement and disarrangement of fragments and splinters, especially in their relation to the joints, were necessarily disarranged by even the most careful dissections. The Roentgen ray depicts these details and all others undisturbed, and as they are in life, and thus leads to clearer understanding and consequently better treatment of fractures. The author has not attempted to produce an exhaustive work on fractures, but has dealt with all the ordinary varieties, which he has fully illustrated with ordinary cuts and skiagraphs. The skiagrams and most of the drawings presented in this volume are originals, being taken from the author's private and hospital practice, the whole representing a vast amount of excellent original work. The typography and illustrations, as well as the quality of the papers, are excellent, and the publishers are to be complimented on being able to give to the profession a work of this eminently practical character on a subject which is brought daily to our notice.

R. C.

**Atlas and Eptiome of Diseases Caused by Accidents.** By Dr. Ed. Golebiewski, of Berlin. Authorized translation from the German. With editorial notes and additions by Pearce Bailey, M.D., Consulting Neurologist to St. Luke's Hospital and the Orthopedic Hospital, New York, and to St. John's Hospital, Yonkers; Assistant in Neurology, Columbia University; Author of "Accident and Injury, their Relation to Diseases of the Nervous System." Forty colored plates and 143 illustrations in black. Philadelphia: W. B. Saunders & Co., 1900. Canadian agents: J. A. Carveth & Co., Toronto.

The book under notice is another of the series of atlases which Saunders & Co. have been publishing during the past couple of years, and this little volume will undoubtedly prove to be one of the most interesting and instructive of the series. The "Atlas and Epitome of Diseases caused by Accidents" is divided into two parts, one dealing with injuries in general and the other with injuries of special parts of the body. The subject with which this little volume deals is important, only recently having been recognized and dealt with as a special subject, and is growing in extent all the time. This book contains much useful information upon the nature and effects of various forms of accidental injury, and should prove very useful to both practitioner and student. Both the translator and the editor have done their work excellently, and the colored plates are extremely good. A good index concludes the volume.

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CANADA
MEDICAL RECORD

DECEMBER, 1900

# Original Communications.

## ODDS AND ENDS IN ORDINARY PRACTICE.

By A. D. STEVENS, M.D., Dunham, Quebec.

### A PLEA FOR THE COUNTRY DOCTOR.

I can quite understand your anxiety to furnish your readers each month with a high-class periodical, and that you have, for the most part, reached the mark there is no doubt. It is only natural that the desire to attain to a high standard should possess you, or, if you prefer it, that your journal should compare favorably with your exchanges or contemporaries. In the meantime, be kind enough to let me ask how are slow and unpretentious men like your humble servant ever to be benefited by the ideal you set up unless you descend more often to their level—down, I say, where matters of every-day, all-round professional life in the country parts are disposed of? We are not anxious for assistance or instruction in opening the abdominal or cranial cavities. No one expects or asks us to master these details, but they *do* expect us to understand our midwifery and the management of diseases proper, with always surgery of a certain kind thrown in. What we seem to require most of the ordinary journalist is that light shall be let in upon our work in such a way that we can use it; we must be always prepared to act in emergencies upon our own resources independently, and stand or fall by the consequences. For the future, then, try and remember us; let us have our share of your pages.

And now, please, do not mind, publish or take seriously to heart this scolding, for I wish to get down to business as

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soon as possible. Do not send me elsewhere for the kind of literature I describe, for I am just now out of change and unable to pay for it.

### Paralysis Agitans.

In a couple of cases of Paralysis Agitans—one recent, the other several years ago—nothing appeared to give as good results as the tincture of Hyoscyamus. It was first suggested for the purpose of allaying the nervousness both suffered from, but I have a strong impression that it effected more than that. Both were males and past the meridian of life when taken; both were previously as fine specimens of our race as you will ever meet in a community of farmers. I did not try Hyoscamine or Hyoscine, for the simple reason that I was not aware, at the time, that either the alkaloids or tincture had been recommended in the disease. But the end came at last; both are now sleeping with their fathers after an illness that lasted for years.

### A Possible Case of Poisoning.

A gentleman living here has five children; the youngest is a year and a half old and the eldest is twelve years of age. Two were at schools a half a mile apart; two were at home and the remaining one out driving with the father. The youngest one was suddenly seized with vomiting and cardiac depression, to be followed almost immediately after by the other child, who, it will be remembered, was at home, and showing precisely the same symptoms. Next, one of the children from one of the schools appeared and was suffering exactly like the other two. Directly after this, the fourth child was brought home from the other school in a strikingly similar condition, and, in a few minutes, the father drove in with the fifth and last child, who was in no way different from the others.

Just about this time it occurred to me that I had better examine the ground I was standing on, and on turning to the parents for light I was informed that the only *one* sort of food that *all* of the children had partaken of was milk. It seems that the father had, the day before, purchased

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two cows, and the whole five had drank of the milk at breakfast for the first time.

And now, if it was not the milk that was at the bottom of the affair, what was it? It is not necessary to say that I claim no very great exercise of skill in the treatment. All, however, recovered in a few hours, and whatever anxiety we experienced soon disappeared.

## HOUR-GLASS CONTRACTION.

Is it not remarkable that I should have been in the practice of medicine all these years and meet with only one instance of hour-glass contraction at the internal os (fully twenty years ago) and one case (a few days since) of contraction at the middle of the uterus? With the single exception of ectopic gestation, I fancy I have seen about everything else that a medical man is expected to contend with in the practice of midwifery.

The confinement that I wish to describe went on well enough apparently until the delivery of the placenta was attempted, when I failed to find it where I expected. As there was then no reason to suspect that there was anything wrong, I waited a few minutes for its arrival down near the mouth, and in the meantime the nurse compressed the womb. However, soon after this it became evident that the patient was flowing badly, and the second attempt was made to reach the afterbirth, with the result that the uterus was found contracted in the middle and the placenta well shut up above the constriction. The next thing to do was to get it out of its prison or enclosure and control the hæmorrhage. With the hand, or rather fingers, arranged conically, the constriction was dilated, the placenta detached and delivered, but not without a little pain and loss of blood on the part of the patient and the loss of more or less perspiration on the part of the doctor. This accomplished, and a full dose of ergot given, a good contraction was secured, and an arrest of the hæmorrhage obtained. The only after-treatment she received beyond the ordinary consisted in washing out the cavity of the womb with a mild antiseptic the next day. Her husband told me yesterday that his wife was all right—as well

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as ever. Previous to this she had quite easily given birth to two children. And here would you mind if I express the opinion that it is not necessary to insist upon the douche, or injection, if you prefer the word, after every case of accouchement? It seems to me that, if the womb is thoroughly cleansed out and well contracted, nature may be safely relied upon to do the rest. So far as my memory serves me rightly, I have never seen a case of auto-infection except in consultation,—that is, in midwifery.

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## NOTES FROM THE CLINIC

OF

DR. F. W. CAMPBELL,

Montreal General Hospital,

Professor of Medicine University of Bishop's College.

Calomel in doses of 1-10 of a grain, combined with a little white sugar, is a very valuable remedy in chronic diarrhœa. Calomel is one of the best of gastro-intestinal sedatives.

The Bi-Sulphide of Carbon poured on cotton in an open-mouthed bottle and held against the forehead will, it is said, promptly relieve nervous headache.

The addition of a small amount of white sugar greatly increases the solubility of borax.

Wine of Colchicum in doses of five to ten minims is useful in obstinate sciatica.

Slippery elm, infused in hot water, is excellent in throat diseases. It is especially valuable in obstinate cases of ptyalism, met with sometimes in the pregnant condition.

Obstinate cases of epistaxis are often benefited by having the patient soak the hands and feet in water as hot as can be borne.

Ergotole for hypodermic injections is preferable to ergotine. In a recent case of hæmorrhage from the bowels in typhoid fever it acted promptly and well. Two injections were given of 20 minims.

If during typhoid fever you notice a sudden fall in temperature, look out for hæmorrhage from the bowels. Give

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a hypodermic of a drachm of ether, and follow it by a hypodermic injection of ergotole (Sharpe & Dome, of Baltimore, make it).

A drop of castor oil, it is said, will relieve the irritation and pain caused by a grain of sand in the eye.

Scarlet fever in colored children is not often seen. In them the eruption is a rich purple.

A combination of caffeine and digitalis is said to produce excellent results in cardiac dropsy. The caffeine increases the diuretic action of the digitalis.

Guaiacol mixed with an equal part of glycerine, applied over the seat of pain (neuralgic), or muscular pain, will often give relief.

The attention of the class is frequently drawn to the study of the physiognomy of disease. The tuberculous physiognomy is a common visitor to the Clinic, and is indicated by marked prominence of the ears, a wedge-shaped face, large eyes and prominent malar bones. Clubbing of the nails is almost constantly present. These indications are often met with before any definite evidence is found in the chest.

Women with varicose veins often present themselves at the Clinic, complaining of a tired, aching, hot feeling in the limbs. This feeling seems aggravated on going to bed, and the legs are moved about from place to place in the hope of finding a cool spot and getting relief. Surgical interference may come to the relief of the patient. Outside of this, very marked benefit may be obtained by careful bandaging with a bandage made of fine flannel. These should be worn night and day, and, if the stockings are worn at night and the bandages are properly applied, they will not need renewing for several days. A set of four bandages will last at least six or more months. They require to be damped and ironed and well rolled, before being applied, after being once on the legs. Patients very soon learn how to properly apply a bandage.

During the past spring several severe cases of urticaria or hives presented themselves at the Clinic. The patients complained of much acute discomfort, and there was consider-

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able systemic disturbance. Fortunately, the cases were of comparatively short duration, and were traceable to some idiocyncrasy or disturbance of the digestive tract. The diagnosis, Dr. Campbell said, was comparatively easy, and can be assisted by learning that the patient has been indulging in some form of shell-fish, or possibly largely of some common fish. According to the severity of the attack, the body will be more or less covered with raised wheels or blebs—white on the summits and red at the base. The lesions are generally pretty uniform, and closely resemble the rash caused by the common nettle, "urtica urens." As a rule, the wheels are not more than an inch or so in size, but occasionally they are several inches, and such cases are called "giant hives." Still more rarely this may become confluent and cover the greater part of the body. Such cases, fortunately, are not common, but when met with the patient is driven to the verge of insanity, so intense is the itching. It occasionally comes out on the palms of the hands and the soles of the feet. Patients so afflicted suffer intensely. In treating this disease, the cause should be discovered, and, if possible, removed. Then a good full dose of sulphate of magnesia ought to be given, with a view of clearing the alimentary tract. The patient should be immersed in a full bath of a temperature of 90°, in which a pound of Bi-Carbonate of Soda has been dissolved. The immersion should last about ten minutes, and relief will be obtained in most cases. If the irritation returns, immerse the patient again. Subsequently put the patient on either Salicylate of Soda, fifteen grains every three or four hours, or Liquor Arsenicalis, two drops every four hours. When the remedies suggested do not give relief to the patients suffering, some Anodyne will be required, and none act better than Nepenthe in doses of twenty drops every four hours till relief is obtained.

Styes are not uncommon at the Clinic. Sometimes they are large and cause a great deal of discomfort. Sometimes a patient is met with who says "he has had a crop" of them. Occulists—some, at least—attribute them to eye-strain. Dr. Campbell says he has had much benefit from bathing the eyes every two or three hours with warm water, or a lotion

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of warm water containing one drachm of Boric Acid to every four ounces. Internally he invariably gives a pill of gr. 1-4 of Sulphide of Calcium three times a day. After they have disappeared, he puts the patient on a mixture containing Compound Tincture of Gentian, Tincture of Nux Vomica and Hydrochloric Acid, which should be taken for at least a month.

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# Selected Articles.

## A CLINICAL LECTURE ON THE PREVENTION OF VALVULAR DISEASE OF THE HEART IN CASES OF ACUTE RHEUMATISM.

*Delivered at the Liverpool Royal Infirmary.*

BY RICHARD CATON, M.D., F.R.C.P.
Physician to the Infirmary.

GENTLEMEN,—It is your constant experience and mine day after day on the medical side of this hospital to meet with cases of organic heart disease. These poor people come to us suffering from dyspnœa, dropsy and weakness after too often a severe struggle to accomplish the daily task needfull for the earning of a livelihood. They have striven hard against increasing difficulties, until at length Nature can do no more, and they come to us almost in despair. We treat them as out-patients, or more frequently take them, into our wards, and give what temporary help we can. Nearly always we get the same sad story from them—a bad attack of rheumatism, after which they were never the same as before; increasing breathlessness, then swelling of legs and feet, and inability for hard work. It is a painful experience for the doctor, especially when, as so often happens the patient is young, and his whole life is blasted by this terrible breakdown of circulation, a breakdown the urgent symptoms of which we can often alleviate, but the underlying essential defect of which we can never repair. Under these circumstances it is not wonderful that some of us have felt the urgent need for efforts to prevent this injury of the cardiac valves in rheumatism from which so much suffering and disablement result. No one can deny that the inquiry is important and is worthy of our best efforts. Nevertheless it is the fact that the great majority of our profession at present, while treating the rheumatic affection to the best of

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their ability, leave the cardiac risk to fate; they are deeply concerned if endocarditis occurs, but believe themselves power less to prevent or influence it in any way.

Many of you have observed the care with which in my wards the heart is examined daily in every case of acute rheumatism, and also that certain rather unusual measures of treatment are applied. They are employed with the object of preventing organic valvular disease. I have told you why I employ these measures; let me explain to you the theory on which the measures are founded, and give you a brief summary of the results which have hitherto been attained, and, finally, I wish to lay down one or two principles which it seems to me we should always keep in mind in the treatment of these cases:

1. On what theory can we reasonably hope to exert any influence on the endocardium, to prevent or assuage rheumatic inflammation, to remove the products of such inflammation, and prevent the crippling of the valve?

In the first place we must stop the rheumatism as rapidly as possible, and prevent all aggravation of it by chills. We therefore keep the patient absolutely at rest in bed; profuse sweats usually occur, in which there is great danger of chill, I therefore clothe the patient from head to foot in a warm flannel garment; a large stock of these vestments is kept in my wards expressly for rheumatic cases. Salicylates are given in full dose, often with alkalies, and cholagogues in such measure as to cause free evacuations but not diarrhæa. The diet is confined to milk and light farinaceous food; no red meat is given for a long time. The patient is kept in bed long after all pain and fever are gone, for never forget that the salicylate treatment, while removing pain and fever in twenty-four or forty-eight hours, does not remove the rheumatic entity itself (what ever that unknown entity may be) after less than two or three weeks of steady administration. The treatment I have thus far mentioned has nothing particularly new in it, but if you carry this out with strictness you will have a low percentage of cardiac complication. Out of many hundreds of cases, I have only had about 15 per cent. of cardiac troubles, which is a low average.

But, even if you do all that, you will have some cases of cardiac trouble, and of course it will often happen that the mischief in the heart has begun before you see the patient. What are you to do when you find that the first sound at the apex is getting soft, that a *bruit* has developed which you can often hear in the axilla, and that the second pulmonary sound has become accentuated in consequence of reflux through the mitral? (*a*) You must keep the patient most stringently at

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rest ; no raising the head, no excitement ; he must have the most perfect physiological repose you can devise. And why? In order to give the heart all the rest possible, to make the intervals between the systoles as long as you can, to keep down blood pressure as far as is praticable. The endocardium when inflamed has dilated vessels and effused lymph and leucocytes in its deep layer. The valve cusps, being thickened and softened, become unable to withstand the pressure waves produced by a powerful systole ; it is possible, in fact, that the regurgitation which occurs, and which alarms us so much, is in itself a beneficial and a protective arrangement of nature lessening the pressure on the cusp of the valve. You know that there are no vessels in the valve cusp itself, but there are many connective tissue canals ; these are affected by the inflammatory process,and from them are effused those vegetations which project from the inner border of the free margin of the valve. Well, in order to protect the damaged valve during its period of infirmity and to give a chance to the restorative processes of nature to repair the damage done, we must give the heart a long and complete rest of several weeks, say five or six at least. (*b*) Next, is it possible to give any help to the natural powers in their strife with the rheumatic dyscrasia in the endocardium? Can we give Nature local help against rheumatic ailmen s anywhere, in the joints, for example? Yes we can unquestionably ; by the application of small blisters close to or just above a joint we can almost with certainty remove rheumatic swelling and pain. No one who has witnessed the results of the late Dr. Herbert Davies' method of treating acute rheumatism by blisters can doubt this for a moment. How is this relief afforded by these very small blisters ? I believe it is solely through their action on the cutaneous nerves and by the resulting stimulation of the trophic nerves of the affected part ; that, I believe, is the explanation of the efficacy of every form of so-called "counter-irritation." We get a stimulation of trophic and vasomotor nerves, and in consequence extra nutritive and reparative activity, and restoration takes place which without such aid might not have been accomplished. We see the same principle exemplified in a most simple and rudimentary form in the healing of an ulcer ; if nature is making no progress towards a cure, we stimulate the indolent tissues by applying such an agent assilver nitrate or some other excitant, and then healing and cicatrisation begin.

Can we in any way stimulate the trophic and vasomotor nerves of the heart ? Is there any channel by which we can reach an organ which seems so peculiarly inaccessible ? Yes, I think there is one way, and only one. Every viscus has

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relations with cutaneous sensory surfaces, as we have learned from the work of Gaskell, Sherrington, Head, Ross and other observers; the heart is in special relation with the first four dorsal intercostal nerves. As those of you who have been clinical clerks have often observed, morbid trophic changes in the heart, such as those involved in angina, degeneration, over-strain, etc., constantly manifest themselves by referred pains in the region supplied by those nerves. Now these are afferent nerves. Is it not at least possible that we can influence the heart by transmitting afferent impulses along these channels? If we stimulate these nerves, a portion of the impulse traverses the cord and reaches the cerebrum in a sensory form, but, as they are in special relation with the cardiac plexus, is it not probable that a portion of the message produces its effect on the heart, not in a sensory form, but as a stimulus to trophic function, as appears to be the case when we stimulate the nerves adjacent to a joint?

This is, of course, merely a hypothesis, and an entirely new hypothesis so far as I am aware, but it does seem to have much to support it, and as our methods of reaching the heart were so few, it seemed worth while to make all the use one could of this one. I have, therefore, for the last fifteen years applied small blisters, each in size rather larger than a shilling, in the course of these nerves—that is to say, over the upper part of the chest, between the clavicle and the nipple on either side. Only one blister is applied at a time, and after each a small poultice is placed on the blistered surface. Practically no pain or discomfort results if the small blistered surfaces are properly dressed and attended to.

(*c*) It is important that all inflammatory exudation should be absorbed and removed from the endocardium and valve cusps as early as possible. If the effused products remain in the substance of the valve and organise, probably the cusps never regain their normal mobility. I have seen a mitral cusp thickened after endocarditis to fully the extent of one eighth of an inch. Such a cusp, of course, cannot flap back in the quickly-changing flux and reflux of the blood current with each systole and diastole. It must necessarily cause stenosis or regurgitation, or both. We have some drugs which are believed to influence absorption, and particularly to attack such effusions into the tissues as are not fully organised and fortified by the ingrowth of nerve filaments and capillaries. The iodides and mercury are of this order. I always give one of the iodides, usually sodium iodide, during the treatment of one of these cases; and sometimes with caution a mercurial.

2. What has been the result of following this method of

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treatment which I have now carried out for fifteen years? Let me first tell you what were the results following a merely expectant treatment carried on during several previous years, treating only the rheumatism and leaving the heart to take care of itself. In a number of my cases which I watched and followed carefully, the patient went out of hospital with a *bruit*, which unhappily was the origin of permanent heart disease, in almost all cases the mitral being the valve in fault. It was this succession of ill consequences which caused me to seek after some better system. After that I experimented the several methods which had been proposed by old writers, but without any encouraging result.

During the last fifteen years I have treated 85 cases of valvulitis in hospital on the plan above described. Of these, 54 already had signs of cardiac trouble, apparently recent when they came under my charge. Of these, after being subjected to the treatment above detailed, 34 left hospital with apparently sound hearts, while 20 had, I fear, valvular disease. Of course in many of these cases one could not be sure that the valvular mischief was really of recent occurence. Thirty-one cases came into hospital with sound hearts (or at least having no *bruit*) and valvulitis occured in hospital; they were treated *ab initio*. Of these, 27 went out with apparently sound hearts, 3 lapsed into permanent disease of the valve, and 1 remains under treatment. This has been a highly satisfactory result. Some of you have seen certain of these cases, but rarely more than one or two, because the series has extended over a period of fifteen years.

After prolonged treatment the *bruit* is found to become soft and to be heard with increasing difficulty; it then becomes variable; sometimes heard and sometimes not. A time comes when it is heard when the patient is recumbent, but disappears when he sits up; at length it disappears altogether and the accentuation of the second pulmonary sound also vanishes. But even after this satisfactory point has been reached, rest and care are required for a time. Many such a case have we watched in these wards. Whenever practicable, we keep the patient under observation for months or years after, and, provided no fresh rheumatic attack occurs, he usually does well.

3. Let me now briefly sum up the principles which in my judgment should regulate our treatment of acute endocarditis: (1) The chief importance of rheumatism consists in the cardiac risks involved. The complaint itself is rarely fatal, and, since the discovery of the utility of the salicylates, it involves a greatly lessened amount of pain and suffering. Its great seriousness consists in the fact that it

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may, and very often does, cripple the heart for life, leaving the patient incapacitated for much of the enjoyment and for all the physical activity which were his birthright, not to speak of the sufferiing and the brevity of such life as remains. If there are any means by which there is even a hope of this great calamity being averted, surely we ought to give it a trial. (2) My own experience has convinced me that in the great majority of cases this calamity can be averted, but only at the cost of a prolonged rest, which in itself is more irksome to the patient than the other details of treatment which accompany it. If, however, the patient is told, in such a manner as not to alarm or distress him, what are the issues involved, he is usually quite willing to give himself a fair chance of recovery. So far as I can judge, the treatment is more efficacious if begun early; if delayed beyond a certain time, it is of no use, at any rate. in the case of adults. In childhood it has seemed to me that the restorative power is greater. I have seen a few cases of restoration of a damaged heart when no treatment but rest was adopted, and even one or two in the absence of a sufficient amount of rest, but my experience tells me these cases are few. Among children rheumatism is not infrequently devoid of pain. A sore throat, a little fever, some aching in limbs, perhaps a few largish spots on the skin, may be all that indicates an attack of rheumatism which, if unobserved, may leave the heart crippled. I advise you to examine the heart carefully in all such cases. Lastly, two brief cautions: If your patient's heart after rheumatic endocarditis appears to have become normal under treatment, warn him to avoid active or violent exertion for two or three months, and also to take every precaution against another attack of rheumatism. If that recurs within three months, the heart is almost certain to be again involved.

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## THE TREATMENT OF THE BREASTS AND NIPPLES DURING PREGNANCY AND THE PUERPERIUM.

By

GEORGE L. BRODHEAD, M. D.,

Professor of Obstetrics, New York Post-Graduate Medical School and Hospital; Instructor in Obstetrics in the University and Bellevue Hospital Medical College: Assistant Attending Physician to the Mothers' and Babies' Hospital; Fellow of the New York Obstetrical Society, etc.

With reference to the treatment of the breasts and nipples during pregnancy, there is little in my opinion to be said. In most cases the breasts and nipples do well with no preparatory treatment whatsoever beyond the usual

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precautions for cleanliness. In other cases, in spite of the most careful preliminary measures, there will be no end of trouble, especially with the nipples. As a rule, the breasts require no treatment, but where the nipples are tender, or small and undeveloped, much good can be accomplished by proper care, especially during the last few months of pregnancy. In all cases the breasts and nipples should be bathed each day with warm water and castile soap. If the nipples are prominent, and not tender, this will be sufficient. If tender, a small quantity of albolene can be applied each night upon retiring, the ointment being placed upon a small piece of sterile gauze. Where the nipples are small, flat or only slightly protruding, the woman should, with perfectly clean fingers, draw them out by careful manipulation for a period of fifteen minutes each day of the eight weeks immediately preceding the time of confinement. For this purpose a lubricant, such as albolene, is to be used. The nipples can in some cases be made eminently suitable for nursing, where without the use of manipulation it would be impossible for the child to take hold. It seems to me that our purpose in the case of the nipples should be, not to harden them, thus making them more liable to crack, but on the contrary tokeep them soft and pliable, in which condition cracking iscertainly less likely to occur.

Taking up, now, the consideration of the breasts and nipples during the puerperium, it will be best to commence with the treatment of the nipples, for the reason that, if proper care be given them, serious trouble in the breasts will be of comparatively rare occurrence. The most direct and most common source of infection in the breasts is through imperfect or careless treatment of the nipples. It is my firm conviction that if the nipples are kept absolutely clean there will be no infection in the breasts themselves. The most essential element then in successful treatment of the breasts and nipples is that of strict attention to the details of surgical cleanliness. The nipples themselves, the child's mouth, the applications and the fingers of the nurse must all be kept as nearly sterile as is practicable. The child's mouth and nipples are to be washed both before and after each nursing with a saturated solution of boric acid made in sterile water. Gauze and albolene that are used for the nipples must be sterile, and the fingers of the nurse or attendant must be clean as well. The patient should not be allowed to touch the nipples at all, and she should be instructed that trouble as a rule takes its origin from dirt coming in contact with the nipple. In the intervals between nursing the nipples are kept covered with albolene on small squares of ster-

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ile gauze. 'There is no other treatment which in my experience equals that just described, and, if carefully carried out, no fear need be felt of abscess of the breast. The plan as outlined was first tried by me some years ago, when Resident Physician of the Sloane Maternity Hospital, with such success in a large number of cases that I have used the same method in pr vate practice ever since. If the nipples become cracked or eroded, there is no treatment comparable to that of the application of ten per cent. nitrate of silver solution. After each nursing, when the nipple has been bathed with the boric acid solution, the crack or erosion is carefully and and gently exposed with the clean fingers of one hand, while with the other the silver solution is applied to the raw surface by means of the cotton-wrapped end of a match or tooth-pick. Just enough solution is used to coat the raw surface of the crack with its albuminous covering, after which the excess of silver is removed with dry cotton and the albolene applied as usual. After several applications have been made the cracks usually heal. If the lesions are large and the nipples very tender, it is advisable to use a nipple shield, at least until marked improvement has taken place. In using the silver solution great care should be used not to apply it in such amount that the entire nipple is blackened and made ugly looking. It is of no use anywhere except in the crack in the nipple, and with care its application can be confined to that portion alone. Breast cases for treatment may be divided into two classes, the first class being comprised of those women who do not nurse and the second of those who do. For various reasons many women either never nurse or nurse for a variable time, then give it up. But in any case where the breasts are not to be used for nursing, the treatment should be as follows : a tight breast binder should be applied immediately after nursing has ceased (or in case of still-birth, on the second day after labor), the nipples being protected by small pieces of sterile gauze. Cotton should be placed in the axillæ, around and between the breasts, and the binder applied as firmly as the patient can bear it with any degree of comfort. When once the binder has been evenly and carefully put in place, it should not again be removed, except for purposes of cleanliness, until the breasts are soft and painless. If the binder becomes loose it should, of course, be tightened ; unless there is good reason for changing the binder, it is much better to leave it in place for the reason that the breasts are often very tender and painful, and manipulation tends to increase the discomfort. The binder should be applied to the breasts with the patient lying in the horizontal position, for the

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reason that in that position the breasts are the more easily held in place, well up on the front of the chest. In many cases the tight binder alone will be sufficient to accomplish the end desired, the milk drying up quickly and with little or no discomfort. In other cases it will be necessary to limit the amount of fluids taken in order to reduce the distention in that way. In all cases where the breasts become caked and tender it is a good plan to administer large doses of salts, the Rochelle being the most pleasant, and as efficacious as any. Salts may be given in plain water, or preferably in Vichy, a half ounce every hour until the bowels have been freely evacuated. The large watery movements will relieve the distention to a great degree, and in the vast majority of cases these measures (binder, limited amounts of fluid and Rochelle salts) will prove successful. There are a few cases where it may be necessary to give small doses of morphine or codeine to relieve the pain, but the treatment as outlined will be found satisfactory in most of the cases. I have relied upon the plan to the entire exclusion of massage, the use of the breast pump, hot fomentations and belladonna ointment. When the binder has been nicely applied it is less painful to leave it in position than to remove it, and resort to the other measures just mentioned for the relief of distention.

In the second class of cases we have to deal with nursing women. In many of our patients nothing more will be necessary than to support the breasts upon the front of the chest during the intervals between nursing, by means of a binder applied in such a way that the breasts are merely held in position, no pressure being made upon them. If the breasts are over-distended, pressure may be used, but, where the milk supply is only moderate, pressure should be avoided for fear of decreasing the amount of milk. The breasts in all women should be supported in some way to prevent the caking which is often the result of a pendulous position. If there is pain and tenderness, the breasts should be carefully massaged by the nurse with clean hands about once every four hours, or less often as occasion may demand. The object of such massage, where caking exists, is not to remove a large quantity of milk from the breast, but to distribute the milk equally throughout the gland. Where the pressure is even throughout there will be little pain, and the supply will soon be regulated to a large extent by the demands made by the child. Fluids should be taken in such cases in limited amounts in order to prevent further distention. Great care should also be taken in such cases to see that the infan nurses well, for when nursing is properly established troubl will usually come to an end. Again, much good can b

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accomplished in cases of over-distended breasts by the use of repeated doses of Rochelle salts, a tablespoonful in a glass of Vichy every hour until the bowels are freely evacuated. The breast pump creates to my mind an artificial demand, and with its use a longer time is required to establish a proper balance between supply and demand. Where, on the other hand, milk is desired for the purpose of feeding a premature infant, or one for any reason too weak to nurse, a breast pump carefully cleaned and properly used is of the greatest possible advantage. Where the milk supply is deficient, massage should be used three or four times each day—large quantities of rich milk, eggs, butter and cream taken and some form of malt extract administered there times a day.

A moderate rise of temperature may accompany distention and pain in the breasts, but as a rule the pulse does not become accelerated to a degree corresponding to the rise of temperature. Where the pulse and temperature suddenly rise to a marked degree, infection is, as a rule, to be strongly suspected, and to those cases, on careful palpation, a painful indurated area may be found in the breast. Where every possible precaution is taken to keep the nipples and breasts absolutely clean, abscess of the breast is exceedingly rare. In a service of several thousand cases at the Sloane Maternity Hospital, there were but few in which abscess was threatened and but three cases in which operation was performed for the relief of such a condition. Even where infection has taken place and we have a painful indurated area in the breast with increased pulse rate, rise of temperature and perhaps a chill, the inflammatory process can be checked and a cure brought about in many of the cases by prompt, energetic, careful treatment. In these cases I believe massage to be of the greatest value, for by that means the pus, which is at first located in the ducts themselves the process not having extended into the connecting tissue surrounding them) can be slowly and carefully removed in part at least and wiped away from the nipple as it appears there with as terile wipe. Massage should be at first made lightly, then gradually with more pressure, the aim being to bring the pus from the gland to the nipple, there to be sponged away. The pain is oftentimes very great, but the patient generally prefers to have it done rather than run the risk of having an operation performed. Massage should be used once every four hours, and during the intervals an ice bag should be constantly applied to the painful area, the breast being held up in proper position with a breast binder. Here again large doses of salts are of great value, and for great pain small doses of codein are of service. If pus is present

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the child should discontinue nursing, but, if not, nursing should continue. I have repeatedly seen recovery follow this plan of treatment, in one case inflammation having occurred in both breasts. One point must be emphasized, and that is, treatment must be commenced immediately upon the appearance of suspicious symptoms and kept up continuously until all danger has passed. I know of no greater satisfaction than to save a woman from operation in case of abscess of the breast by careful systematic treatment. Where treatment fails, the area of inflammation increases and the skin becomes reddened, there is, of course, the necessity of free incision, curettage and the usual treatment for abscess in any other part of the body. The incision should be in a line radiating from the nipple so as to cut as few ducts as possible, and should be extensive enough to open up all the pockets which may exist in the inflamed area. After hemorrhage has been checked by packing the wound with iodoform gauze, a wet one per cent. carbolic acid dressing is applied. On the following day the wound should be lightly packed with a strip of wet carbolic gauze (one per cent.) and the wet dressing changed each day until the wound is ready for a dry dressing. Breasts treated in this way heal in the course of several weeks, and in subsequent puerperiums nursing may go on in a natural way unless too much of the glandular tissue has been destroyed by the inflammatory process.

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## TYPHLITIS: EXTREME CASE OF BLOOD CURED.

By T. J. BIGGS, M.D., Stamford, Conn.

Henry S., aged 39; American; admitted June 2nd, 1900. Diagnosis: Typhlitis.

The patient had been suffering for a week prior to entering the hospital. It appeared that his condition began with pain and tenderness in the right iliac fossa, and along the ascending colon. An examination at the time of his entering the hospital revealed a slight prominence in this region. At first the bowels had been constipated, but now small liquid stools occurred every two or three hours. This was due to accumulation of the hardened fæces in the sacculated periphery of the cæcum. He also suffered with much local pain and tenderness. Temperature was 103½; he was very restless and had occasional attacks of vomiting, and almost constant nausea. The vomited matter at first contained the contents of the stomach, but in 24 hours the con-

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tents of the duodenum contained a great deal of bilious matter. He was suffering from great depression of the vital powers. Peritonitis had developed on the right side.

The patient was put to bed, placed on a strict bovinine diet, a tablespoonful in milk being given every two hours. He was also given a thorough rectal purge, followed by small doses of morphine to control the pain.

For the first 24 hours he retained the bovinine nicely, but on the afternoon of the third he vomited everything, even water. The quantity of the bovinine was now reduced to twenty drops in a little iced grape juice every hour. The bowels were cleaned out, first by injecting a pint of olive oil, then later a soap suds and glycerine enema. This was followed by a large evacuation.

On the 5th the patient could not retain anything by stomach, so it was decided to treat him per rectum. Consequently, he was given three times a day a high rectal feeding, consisting of four ounces of bovinine, four ounces of milk and an ounce of lime water. These were retained, and the patient began to show improvement.

On the 10th the pain and tenderness in the right iliac fossa had almost subsided, the fever had dropped down to 100 1-5, bowels were moving normally. The bovinine was now resumed per stomach, half a teaspoonful every hour in lime water, and the rectal feedings employed twice in twenty-four hours.

On the 16th the temperature was normal, pain and tenderness over the right iliac fossa had entirely disappeared, patient not nervous, and the stomach retained the bovinine feedings without any inconvenience. The rectal alimentation was now discontinued, and bovinine ordered, a tablespoonful every two hours in a little peptonized milk and lime water.

On the 20th the patient was up and about, complained of no pain, bowels regular, all soreness and swelling had disappeared from the abdomen, and his strength was excellent. The bovinine was now ordered, a wineglassful every three hours in peptonized milk.

On the 26th he was allowed a light general diet, and the bovinine was given three times a day. On the 28th he was discharged cured.

This case, prior to coming into the hospital, had been under treatment by two competent surgeons, and they both advised immediate operation. Consequently, I deem this to be a remarkable case, and one of much clinical interest to the profession at large.

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# Progress of Medical Science.

## MEDICINE AND NEUROLOGY

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine University of Bishop's College; Physician Western Hospital.

### THE PREVENTION OF TUBERCULOSIS.

The Tuberculosis Commission of Munich (*Philadelphia Med. Jour.*, March 24) has formulated regulations for the prevention of tuberculosis :—

" 1. The periodic disinfection of all localities much frequented by the public, especially rooms in which many individuals congregate, such as schools, society rooms, churches, cafés, restaurants, hotels, orphanages, barracks, libraries, convents, hospitals, dispensaries, stores, tramways, railroad cars and cabs.

" 2. The prohibition of spitting on floors in rooms and public conveyances ; the placing of cuspidors in parks and other public places and in vehicles of transportation.

" 3. The establishment of special play-grounds for children, in order to avoid their playing in localities which phthisical patients might visit.

" 4. The disinfection and whitewashing of rooms where a case of phthisis or a death from that disease has occurred.

" 5. The annual medical inspection of persons frequenting schools, academies, offices, factories, etc. Any cases found should be reported to the authorities.

" 6. The establishment of people's sanatoriums.

" 7. The hygienic instruction of the tuberculous, so that they may be able to protect themselves and those coming in contact with them.

" 8. The isolation of the phthisical cases in military and general hospitals ; if possible, the erection of separate pavilions.

" 9. The prohibition of the bathing of the tuberculous with healthy persons ; the establishment of separate bath houses for the former, under medical supervision.

" 10. The removal of all tuberculous individuals from the schools, and their transfer to colonies in the country, where they may be treated.

" 11. The formation of committees with the object of sending the children of poor persons who are suffering with

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tuberculosis, or who have died of that disease, into the country in order to remove them from the infected houses. The children of rich families should also be removed from their homes for a certain length of time.

" 12. The improvement of the hygienic and dietetic conditions of the poorer classes by the erection of public kitchens, wayfarers' lodges, bath houses, etc.

" 13. Philanthropists should make it their object to improve the nutrition and hygiene of individuals in poor families in which tuberculosis has occurred.

" 14. The linen of tuberculous persons must be disinfected before being brought into contact with the linen of others.

" 15. The marriage of very young persons whose appearance suggests that they are inclined to tuberculosis should be opposed. Persons in whose sputum bacilli are present should be prohibited from marrying.

" 16. The compulsory periodic examination of domestic animals which might become tuberculous.

" 17. The monthly inspection of stables; supervision of the hygiene of the kitchen, of milking and milk vessels; scrupulous care in creameries.

" 18. The supervision of markets and abattoirs.

" 19. The erection of stations at the borders of countries for the inspection of imported animals.

" 20. Strict regulations regarding the products of factories.

" 21. The giving of weekly lessons in hygiene at public schools.

" 22. Each child at school must have its own drinking cup and its own towel.

" 23. Instructions to second-hand dealers in books, clothing, etc., to have their wares disinfected. Disinfection of library books, as well as of objects that serve for school or general use, must also be performed at certain intervals."—*Modern Medicine.*

## RATIONAL TREATMENT OF NEURASTHENIA.

Dr. Frederick A. McGrew (*Journal of the American Medical Association*, June 9, 1900) classifies his cases of neurasthenia under three heads: (1) development neurasthenia; (2) overstimulation neurasthenia; and (3) developmental plus overstimulation neurasthenia. The developmental neurasthenic needs such exercise (*not rest*) as shall tend harmoniously to develop and strengthen every part of the physical organization, change of diet and surroundings, combined with stimulating and eliminative hydrotherapeutic measures

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and massage. The overstimulation neurasthenic will be best benefited by complete rest. Dieting, general massage combined with passive movements, special abdominal massage, fomentations along the spine and over the stomach and liver, saline sponging and general faradism are measures promoting the elimination of fatigue and waste products and increasing the general muscular and arterial tone. In a neurasthenia in which the developmental and overstimulation elements are both concerned, it is a delicate matter to determine how much is due to insufficient nervous vitality and how much to the abuse of what vitality there is. For the purpose of treatment an approximate estimate must be made, and a course plotted accordingly.—*New York Medical Journal.*

## THE INFLUENZA HEART.

Saundby ("The Influenza Heart," *Birmingham Medical Review*, November, 1898) divides the cardiac troubles of influenza into functional and organic. The functional troubles are alterations in the rate and rhythm of the heart's action, more often of the nature of bradycardia, less often of tachycardia. Those of an organic nature are cardiac dilatation, with indications of insufficiency of the left ventricle. The treatment Dr. Saundby finds most valuable in functional cases is rest, careful attention to diet and the functions of the stomach and intestines, with small doses of iron, arsenic, and in some cases, when there is persistent rapid action of the pulse, digitalis. When the heart is dilated, in addition to the above measures, Dr. Saundby desires to urge very earnestly the supreme utility of the Schott or Nauheim treatment. After four years' experience of this system, he is convinced that for cases of simple dilatation of the heart no other treatment can approach it in value.

Bunch ("On some cardiac affections due to influenza," *Treatment*, February 8, 1900) for the influenza heart advises rest for a large portion of the day, and Oertel's or the Schott treatment when there is cardiac dilatation. Of drugs he finds strychnine very useful in curing arhythmia, and for relieving precordial discomfort and the sense of anxiety and sleeplessness, there is nothing so valuable as morphia.

Abée ("Favorable results of compression of the cardiac region in patients with organic lesions of the heart," *La Semaine Médical*, 31st January, 1900), noticing that the subjects of organic disease of the heart often are relieved by pressing with their hands over the cardiac region, has tried the effect of pressure by the aid of a thick pad on the im-

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provement of certain troublesome cardiac symptoms, which resist all other methods of treatment. He tried this in 29 patients, of ages varying from 30 to 45 years, suffering from valvular lesions, aneurism of the aorta, arterial sclerosis with myocarditis, and Graves' disease, with cardiac hypertrophy. In all these cases, and especially in those with cardioptosis, wearing the pressure pad has wonderfully improved the dyspnœic and painful phenomena, and made it easier for the patients to sleep.—*Medical Chronicle.*

## THE CHEMICAL DIAGNOSIS OF GASTRIC DISEASES.

Vaughan Harley thinks that chemical methods in the diagnosis of gastric affections have been greatly neglected in England, although the stomach tube and an analysis of the gastric contents are frequently indispensable. The only contra-indication is recent hæmatemesis. Since the stomach reacts differently to different stimuli, standard meals must be employed. In analyzing the contents Ewald's, which consists of two cups of weak tea and two slices of dry toast taken an hour before the contents of the stomach are removed, gives the best results. For the investigation of the motor power of the stomach Leube's meal, consisting of ¼ lb. of freshly-minced meat and a little bread taken while fasting, is the most satisfactory. Four, five to seven hours afterwards the tube is passed, and any remains of the meal are noted. Normally there should be no residue after five or six hours. When there is increased gastric irritability, and consequently increased mobility, the stomach may be empty between the third and fourth hour, but with lessened motility a residue may be found even sixteen hours after the meal without any pyloric stenosis. The motor power may also be investigated by giving salol and testing the urine every ten minutes with perchloride of iron until a red color appears. This occurs normally in about one hour, but in a case of deficient motility may be delayed for four or five hours. It is an obviously inconvenient method. After having analyzed the contents and tested the motor power, the size and position of the stomach should be determined by percussion after distending it with gas, either by blowing down a stomach tube or by giving half a drachm of tartaric acid and followed directly by the same quantity of bicarbonate of sodium. This is preferable to the other numerous methods, including gastrodiaphany. 1. The total acidity and the free HCl are increased in gastric ulcer, digestion being usually quicker than normal. 2. Acid dyspepsia may be divided

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into cases where (*a*) the excess of acid is due to HCl (hyperchlorhydria), and (*b*) where it is due to increase of the volatile acids. These latter cases are those which benefit the most by bismuth and sodium carbonate taken some time after meals. On the other hand, in hyperchlorhydria, unless the cause is removed by dieting (plain food with no pepper, mustard, or spices, and but little table salt), bismuth and prussic acid mask the symptoms while fermentation increases and at once dilatation supervenes. Hyperchlorhydria is usually accompanied by increased motor power; its chief symptom is pain, coming on three or four hours after food, and relieved at once by taking more. (*c*) Another form of hyperacidity is gastro-succorrhœa, where, though fasting, the stomach may contain a considerable amount. It is generally due to worry, and may be intermittent or constant. 3. In malignant disease a deficiency or absence of free HCl may help the diagnosis in a doubtful case, though there may be a complete absence of it in other conditions also, such as neurotic dyspepsia. Mucus and lactic acid are increased. 4. All cases of gastric trouble, usually described as functional, now come under the head of neurotic dyspepsia. In this HCl is absent or diminished, the volatile acids are increased, often enormously, the digestive power is delayed or totally absent, the motility is diminished, dilatation is usually and gastroptosis nearly always present. In an uncomplicated case mucus is not increased. The ordinary signs of neurasthenia, though commonly, are not always present. Analysis in these cases is of the utmost importance; for instance, in one of the author's cases a diagnosis of gastro-succorrhœa would have been made from the symptoms, but in reality HCl was entirely absent. Treatment is largely hygienic. Internal faradism is most useful, though Weir Mitchell's treatment also is essential in bad cases. NaCl should be withheld as much as possible. The diet should be dry, and liquids taken only as hot water an hour before or three hours after meals, the chief of which should be in the middle of the day. Of drugs strychnine and arsenic are the most useful, though opium is occasionally necessary. When HCl is deficient sodium bicarbonate may be given an hour before meals. Regulation of the bowels is a necessity. 5. Since the introduction of the stomach tube most cases of what used to be called gastric catarrh are now placed among the neuroses. Genuine gastric catarrh almost always depends on some irritant, such as alcohol, tobacco or spices. The gastric contents resemble those fouud in ordinary neuretic dyspepsia, though mucus is always present, generally in excess.—*Practitioner.*

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## CONTINUOUS USE OF DIGITALIS IN HEART TROUBLES.

J. Groedel, in the *Practitioner* for April, 1900, says that cardiac insufficiency is an inevitable result of advancing heart changes. Compensation is established in most cases of valvular disease and may last for months or years, but if the patient lives there is sure to come a time in which heart failure is more or less pronounced. In those cases he recommends continual administration of digitalis, and advises that we should not wait until signs of want of compensation develop, such as dropsy, anemia and tachycardia. He recommends that the digitalis be given in doses of from eight to ten grains once each week. At such wide intervals the drug has no cumulative effect, but during its administration the quantity of urine should be carefully determined, and if it is not augmented the drug should be withdrawn. In the great majority of cases the digitalis is well borne by the patient, and the charge which is made that the drug causes a loss of strength and increases the weakness of the patient is unfounded, these changes occurring as a result of the disease for which the drug is given, and not of the drug itself. He is convinced that where fatty degeneration is markedly benefited by digitalis there is sometimes a subjective cure of these cases.—*Gaillard's Medical Journal.*

## HOT AIR IN CHRONIC RHEUMATISM.

T. L. Satterthwaite recently read a paper before the New York Academy of Medicine on this subject, an abstract of which appears in the *Medical News* of April 14, 1900. He says that the application of superheated air was originally suggested in *Medicine* by Turkish baths. A patient in a simple warm chamber rebreathes the products of his own respiration. In a Turkish bath the temperature cannot be raised above 170° F.; in the hot air, parts of the body can be subjected to a temperature of 400°. The main idea in the apparatus so far devised for giving the hot-air treatment has been to keep the skin dry while the air is heated all around the limb or part of the body that is to be subjected to the high temperature. For this purpose, when the temperature to be borne is not very high, the part is simply covered with a Turkish towel. When temperatures above 300° F. are to be employed, the part must be carefully wrapped and no spaces allowed to exist between the cloth and the skin; otherwise the perspiration at these points will become so heated as to scald the patient. Machines properly constructed should be so lined with asbestos that

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the patient may not come in contact with the heated metal. Glycosuria is not a contraindication for the hot-air bath, but in anemia, fatty degeneration and arterial sclerosis it may be dangerous. The rise of pulse and temperature, and a certain tendency to increase of blood-pressure, would seem to make it unadvisable to use it in such cases.

When a limb is subjected to hot-air treatment, there is first a lessening and then an increase in the circulation of the skin, with the injection of the peripheral capillaries and a sense of warmth. The pulse gradually rises until it is from ten to twenty-five beats higher than it was when the treatment began. There is a rise of temperature of from one to five degrees. There is usually an increase of respiration up to twenty-two or twenty-four per minute. A general sense of comfort comes over the patient and continues as long as the treatment is doing good. After a time, which is variable in different patients, a nervous depression supervenes, which should not be allowed to continue. As a rule, the treatment should stop just short of this, and then it will have its maximum effect.—*Gaillard's Medical Journal.*

## THE RATIONAL TREATMENT OF PNEUMONIA.

SIR HERMANN WEBER, in a recent article in the *Practitioner*, gives some interesting summaries respecting the results of different methods of treatment pursued in Bonn and in London in the treatment of pneumonia. The mortality is higher in Bonn than in London, being from fourteen to seventeen per cent., while in London the death rate is twelve to fourteen per cent. The remedies recommended are blood abstraction and tartar emetic, opium and salicylate of sodium. One would not expect to see a very great difference in the results, whichever one of these remedies might be employed.

It is very strange indeed that the profession is so slow to lay hold of the powerful therapeutic means offered by hydrotherapy for combatting this disease. It has been shown again and again by statistics of undoubted reliability that the mortality in pneumonia may be reduced to four or five per cent. by the judicious use of hydriatic measures. The cooling compress (applied at 60°, changed every fifteen to forty minutes), the prolonged neutral bath (88°-94°), and especially wet-sheet packing prolonged to the sweating stage, have been shown to be therapeutic measures of the highest value in the treatment of this grave malady.

The writer had a good opportunity to observe the value o

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the hydriatic method of treating this disease a few months ago on the occasion of a visit to Old Mexico. While spending a short time at the Guadalajara Sanitarium, Guadalajara, Old Mexico, we were asked to visit a Mexican gentleman who had been sick with pneumonia for one week. He had employed six physicians, and had finally been given up to die. We found the patient extremely low,—pulse 146, respiration 44, temperature 100½°. The patient was so feeble that he could barely whisper, his lips were blue, and the skin cyanotic. Shortly after we first saw the patient he became so wildly delirious that four men were required to hold him in bed. He had had no sleep whatever for several days.

Vigorous hydriatic treatments were at once employed. The means consisted chiefly in a short fomentation to the chest every three or four hours, followed by the heating compress at 60° and changed every twenty minutes. Cold mitten friction (for description, see *Modern Medicine* for May) and the cold towel rub administered every two to three hours. The wet-sheet pack was applied and continued until evidence of perspiration appeared. The patient fell asleep during the second application of the pack, and awoke with his mind clear. At the end of three days convalescence was established, and the patient made an excellent recovery. It is interesting to note that so eminent an authority as Sir Samuel Wilkes (*Practitioner*, February, 1900) condemns the employment of digitalis, asserting that it will not lessen the pulse except when given in injurious doses. He also condemns blisters on the chest, and speaks disparagingly of the use of cold, but evidently because it has not been properly used. Continuous cold to the chest is not to be recommended in pneumonia, but intermittent cold applications, such as the cold compress applied at 60° and allowed to remain from fifteen to forty minutes, or a sufficient length of time to become warmed by the body heat, are exceedingly valuable. By this means the tendency to stasis in the pulmonary vessels is antagonized, and leucocytosis is encouraged. With each application of cold the blood vessels are contracted, and the lung is, so to speak, squeezed, and the blood vessels are emptied of their contents. As the compress warms the blood vessels of the lungs relax, and new blood flows in, bringing with it a fresh supply of leucocytes. By this means a continuous procession of fresh leucocytes is supplied to the lungs, passive congestion is antagonized, the vital resistance of the tissues is increased, the temperature is lowered, the heart action is sustained, and the healing powers of the body are thus aided in the restora-

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tion of the patient. Insomnia, cerebral congestion, delirium and elevation of temperature are easily combatted by means of the wet-sheet pack. In cases of hyperpyrexia a cooling pack may be employed. In this the wet-sheet is renewed several times, the duration being lengthened each time. The first sheet is changed at the end of eight or ten minutes, the second at fifteen minutes, the third after twenty minutes. The patient is allowed to remain in the fourth sheet until reaction is complete and perspiration is encouraged, although the pack should not be continued longer than from one to two hours, even if perspiration does not appear. The pack is especially valuable in cases of this sort, for the reason that it congests and stimulates the skin, thus relieving both the pulmonary and cerebral congestion.

Hydrotherapy certainly affords the most rational measures for the treatment of pneumonia. With the extension of the practical knowledge of hydriatic methods, the mortality may be reduced to one third or even one fourth the present rate.—*Modern Medicine.*

## THE EHRLICH DIAZO REACTION.

By Dr. J. R. ARNEILL.

*Am. Jour. Med. Sc., Post Graduate.*

The author states that if the diazo test is applied in a routine way, and alone depended upon for the diagnosis of typhoid fever, the vast majority of the cases can be correctly diagnosticated. The crucial part of the test, he says, is the production of a pink foam after the characteristic red ring.

The Ehrlich diazo-reaction is a color reaction, and depends upon the production of dyes by the chemical union of suitable organic substances with a diazo compound. In carrying out this test two solutions are required, which are termed respectively Solutions I and II.

| | Reagent. | |
|---|---|---|
| Solution I..... | Sulphanilic acid..... | 1 |
| | Hydrochloric acid..... | 50 |
| | Distilled water, ad..... | 1000 |
| Solution II..... | Sodium nitrite..... | 0.5 |
| | Distilled water, ad..... | 100.0 |

To fifty parts of Solution I. add one part of Solution II. and shake. To a few c.c. of this mixture, and an equal quantity of urine, add a quantity of ammonia equal to about one-eighth of the combined volume of the mixed urine and solution, letting it run down the side of the test tube.

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At the point of contact of the ammonia and the mixture, colored rings of various tints form, ranging from light yellow, through dark yellow, orange and brown, to eosin or garnet, depending upon the urine. The formation of a red zone is an indispensable part of the true Ehrlich diazo reaction. It is also essential that, on shaking, the foam takes on a pink color. This color varies considerably in its intensity, depending upon the strength of the reaction, from the palest rose to the deepest pink, *but must not be any other color*, such as salmon, orange, etc. A third part of the reaction, which the author disregards, consists in the separation of a greenish-black or violet-black precipitate, which forms a layer on the surface of the light-colored sediment when the tube has been allowed to stand for 24 hours.

If the mixture of Solutions I. and II. is not used immediately it should be placed in a dark bottle and kept as cool as possible. The urine likewise should be as fresh as possible.

The cause of the reaction is not known. It has been attributed to diacetic acid and to acetone. In polyuria the reaction may disappear, but on concentration of the urine the test becomes positive. Various materials, such as bilirubin, urobilin and carbol, interfere with the reaction somewhat, but can be removed by sugar of lead or animal charcoal.

The author uses 40 parts of Solution I. instead of 50, and no attention is paid to the green precipitates.

The author gives a table, comprising the results obtained in 405 cases, representing eighteen different diseases in which it is seen that the diazo reaction is practically limited to one acute and one chronic disease, namely, typhoid fever and tuberculosis. Out of 81 positive reactions, 19 were in typhoid fever and 42 in tuberculosis.

The question often arises, does the intensity or duration of the reaction correspond with the severity or length of the fever? The author answers in the affirmative as to the duration of the reaction. If a patient with the clinical symptoms of typhoid fever comes under observation toward the end of the second week of the disease and diazo is absent, the chances are that the infection is on the decline and a mild course is to be prognosticated. If, on the other hand, the diazo continues and increases in intensity, the case is liable to be prolonged and more serious.

To illustrate the constancy with which this reaction is present in typhoid fever, the author gives the statistics of different investigators. In his own series it was present in 19 out of 22 cases. Hewetson found it in 136 out of 196 cases. The combined cases of Ehrlich, Spiethoff, Brecht, Brewing, Paterson, Jez and Nissen number 178, of which

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174 gave the reaction. Rivier has collected 536, of which 520 gave the reaction. Gerhardt says that in his clinic during a period of five years only one *bona fide* case of typhoid fever, which was proved post mortem, failed to give the diazo reaction. Zinn found the reaction in 75 per cent. of cases. Clement found it in 135 of 156 cases. Greene obtained a positive result in 28 of 29 cases. Friedenwald found it in 20 of 21 cases, and Dawson in 44 of 85 cases.

Out of a total of 82 cases of *tuberculosis* observed by the author, the reaction was shown in 42. In cases of pulmonary tuberculosis in which the diazo reaction is found continuously for some days, the author believes, with Michaelis, that grave prognosis should be made. Furthermore, he states that all such cases of tuberculosis may be considered in the third stage of the disease. According to Clemens, on an average between 20 and 30 per cent. of consumptives give the reaction. The prognostic value of the reaction in this disease can be gathered from the fact that in 100 of Clemens' fatal cases 87 of them gave the test. Michaelis states that the great majority of consumptives who show a marked diazo reaction for several days die within half a year. In 88 cases, which he collected since 1896, 63 gave a positive, 25 a negative reaction. Of the 63 diazo cases, 50 died in the hospital, 5 left unimproved, 2 were transferred and 6 improved. Of the 25 cases without diazo, 20 improved, 1 left cured, 2 died and 2 did not improve.

In *measles*, statistics show the reaction to be very constant. Combining the statistics of Brewing, Brecht, Fischer, Nissen, Rivier and Clemens, we have 96 cases, in which the reaction was positive in 86.

In deciding upon the clinical value of Ehrlich's diazo reaction, says the author in conclusion, we can fairly discard the work of all investigators who have not performed the test in accordance with the directions laid down by Ehrlich or who have not considered the pink foam as the important factor in the test.

## FECAL IMPACTION.

The diagnosis of retained feces is really a very simple matter, and it is, on account of its simplicity, very often neglected by the practitioner, whose prevailing fault is to shoot with raised sights, and oftener overshoots the mark than otherwise. The color of the daily evacuation is a very good index. Black or very dark green stools indicate that the feces are ancient. Feces that pass promptly through on time are of a light yellow color. Offensive odor is a certain sign of

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decomposing feces in the bowel. Normal excreta do not smell offensive, and are nearly odorless. A foul, fetid breath is an almost certain indication, and is often erroneously referred to other conditions. But, above all these, a physical examination is so simple and so satisfactory that we need never be mistaken. Place the patient on his back with the knees well brought up; place one hand on the abdomen below the tenth or eleventh cartilage, with the fingers of the other hand in the posterior hypochondriac region. Either the ascending or descending colon can then be pressed forward against the hand on the abdomen. Keep this hand firm and immovable and there will be no difficulty whatever in detecting any accumulation. Percussion sounds are often unreliable, owing to accumulations of gas, which give a resonance where dullness should indicate impaction; but conjoined manipulation is quickly practiced and completely satisfactory in all cases except extremely obese patients, and in these the rectal tube will soon tell the tale.—*Medical Era.*

## NEURALGIC PAIN.

I noted, somewhere, that a writer recommended for the spasmodic contractions of the uterus, during some cases of childbirth, ten or twelve drops of guaiacol rubbed gently over the uterus; it quieted the pains, rendering them more steady and lasting. I thought that. if it eased such neuralgic pain, it might also ease facial neuralgia, and tried it in a case of ciliary neuralgia—five or ten drops were gently stroked into the skin and the relief was immediate. I tried it in several cases of muscular pain with same results. In one case, a negro woman, who had suffered all night from pain in the neck resembling torticollis, went to sleep in less than five minutes. I would have reported it sooner, but thought everybody knew it. Wet the finger from mouth of vial and gently rub it into the skin; that is all, and the pain stops. It is, as Dr. Burgess says, "wonderful" how quickly it eases pain. Do not rub it in hard on delicate skin, as it sometimes causes a little smarting.—DR. BRODNAX.—*Summary.*

## CHOREA.

S. D. Hopkins, in the *Journal of the American Medical Association*, reports on the treatment of nineteen cases of chorea. He has obtained the best results with antipyrin, which is given according to the method of Dr. Eskridge. The drug is given in increasing doses, the initial dose being as many

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grains as the child has years, and increased 1 grain a day. In mild cases the antipyrin is given in the evening, but if severe it is given three times a day. In the mildest cases the patient is allowed to sit up part of the day, but in severe cases absolute rest in bed is enjoined. Antipyrin is not given if there is fever, or if the heart is weak. As soon as the choreal movements cease, or become greatly diminished in severity, the antypyrin is stopped and small doses of arsenic and iron are ordered.—*Pediatrics.*

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# SURGERY.

IN CHARGE OF

ROLLO CAMPBELL, M.D.,

Lecturer on Surgery, University of Bishop's College ; Assistant-Surgeon, Western Hospital ;

AND

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## SPINAL COCAINE ANESTHESIA.

J. B. Murphy, in the *Chicago Clinic* for September, 1900, calls attention to the fact that cocaine injection in the subarachnoid space of the spinal canal was first administered by J. L. Corning, but of late it has been exploited and its practicability demonstrated by Tuffier. The writer claims that in this new method of anesthesia we have one that is easy of application and by it all tissues are rendered analgesic below the diaphragm. The sense of touch is not impaired, the reflexes are absent, and the consciousness of the patient is retained. Tuffier has had an extensive experience with the method, and reports no untoward results. The article reproduces the communication of Tuffier, which appeared in *La Semaine Médicale* of May 16, 1900.

The operative technique as described by Tuffier is as follows: The patient is in a sitting posture, both arms carried forward. The fluid is thoroughly ascepticized and the iliac crests located. An imaginary line connecting these two crests passes through the second lumbar vertebra. The medullary canal is easily penetrated at this point. As soon as this is located the patient bends forward, which causes a separation of about 1.5 centimeters between the vertebræ. The needle is inserted to the right of the spinous processes about one centimeter from the middle line.

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As soon as the needle enters the subarachnoid space cerebro-spinal fluid escapes drop by drop, which is an indication that the needle is in proper position. The cocaine solution should not be injected until the spinal fluid is observed to flow out. About one cubic centimeter of a two-per-cent. solution is injected slowly, the whole quantity being introduced in about one minute. The total quantity of cocaine should not exceed fifteen milligrammes. In from four to eight minutes the patients complain of a tingling sensation and numbness of the feet. At this time operation may begin. In from four to ten minutes after the injection, analgesia is usually complete. Most frequently it extends to the thorax, and occasionally as high as the axilla. The author has employed this method of anesthesia in nine cases; one was for an operation for a pyosalpinx; two operations for varicose ulcers, one an amputation of an ulcerated and painful stump, one for tumor of the ovary, one for strangulated hernia, one for suppurative epididymitis, one for arthrectomy of the left knee-joint, and an appendectomy. In several of the cases there was nausea and vomiting, but in none were there untoward symptoms.—*Medicine.*

## INGROWING TOE-NAIL.

For that very painful affection, ingrowing toe-nail, the following treatment is very strongly recommended by Dr. Kinsman in the *Columbus Medical Journal.*

1. Remove all pressure from nail by cutting away a piece of the shoe.

2. Disinfect with hydrogen dioxide until no more "foam" appears.

3. Apply a drop of strong solution of cocaine in the base of the ulcer.

4. Apply a drop of Monsell's solution to the ulcer, then cover loosely with gauze. Repeat this process every second day until the edge of the nail is released by the retraction of the hypertrophied tissue. The patient suffers no pain from the application, and all pain has disappeared the second day. The cure is effected in a week or two without inconvenience or interference with business.

## A NOTE OF THE SAFEST METHOD OF REMOVAL OF THE APPENDIX.

A. A. Warden advocates Doyen's method, which he describes as follows: The little mesentery of the appendix is first ligatured with a small silk ligature to free the appen-

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dix laterally. Then (1) the base of the appendix is gently crushed with Doyen's small clamp. Almost any forceps suffices for this purpose if strong enough and broad enough completely to occlude the appendix for a breadth of, say, a quarter of an inch; (2) a fine silk ligature is thrown round the base of the appendix in the furrow left by the clamp; (3) the appendix is then removed by the thermo-cautery cutting close to the ligature; (4) a purse suture is then made in the serous covering of the cæcum close round the base of the appendix (as this purse-stitch is drawn tight the little stump is invaginated so that all is completely closed); (5) for safety a second fine silk purse-stitch is made and the little pucker of the first stitch is similarly invaginated and the ligature is gently tightened. The result technically is perfect, and certainly this is the most aseptic method of removing the appendix.—*Lancet, N. Y. Med. Rec.*

# Therapeutic Notes.

## Chronic Urethritis.

| | |
|---|---|
| Sulph. hydrastiæ | 20 grains. |
| Listerine | 1 ounce. |
| Solution of morphine (Magendie's) | 5 drachms. |
| Aquæ, q.s. ad | 8 ounces. |

M. Sig.: Inject three or four times daily, and retain in urethra three to five minutes.

## Salicylate of Methyl in Painful Erections.

Dr. Baratier, of Jaugory, describes a method which he used with success in three patients suffering from gonorrhœa attended by extremely painful nocturnal erections. He prescribed baths and large doses of Vichy water. Inunctions of the penis were made for several minutes with :—

℞ Salicylate of methyl ..... 15 grains.
Liquid vaselin ..... 2½ drachms.

The penis was enveloped in a light layer of absorbent cotton, kept in place by a bandage of gummed taffeta.

The inunction soon diminished the pain and seemed to reduce the force of the erection. In other respects the gonorrhœa followed its usual course.—(*La Tribune Médicale.*)

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### PERSPIRATION OF HANDS.

℞ Sodii boratis,
Ac. salicyli, of each.....6 drachms.
Ac. boric.....80 grains.
Glycerini,
Spiritus dil., of each.....3 ounces.
M. Sig.: External use. To be applied with friction three times a day.

### IMPETIGO OF FACE AND SCALP IN NURSING INFANTS.

℞ Ac. salicylici.....15 grains.
Bismuthi subnitrat.....5 drachms.
Pulv. amyli.,.....2 drachms.
Ungt. rosæ.....1½ ounces.
M. Sig.: External use.

If the impetigo is of the dry, squamous variety, use the ointment by inunction, frequently repeated. If moist, apply a thick coat of the ointment on gauze. Pruritus and congestion will rapidly diminish while the new, healthy epidermis forms under the ointment-crust. (*Kistler Medical News.*)

### ENTERALGIA.

℞ Spiritus ammoniæ aromatici.....1 ounce.
Spiritus chloroformi.....1 ounce.
Spiritus camphoræ.....2 drachms.
Tincturæ hyoscyami.....4 drachms.
Ext. cannabis Indicæ fluidi.....1 drachm.
Tincturæ cardamom comp., q.s. ad...6 ounces.

M. Sig.: Two teaspoonfuls in water every hour or two until pain is allayed.—(*Journal of the American Medical Association.*)

### FATTY HEART.

Dr. A. Robin recommends the following :—
℞ Sodii arsenatis.....1-64 grain.
Potassii iodidi.....¾ grain.
Pulv. nucis vomicæ.....⅛ grain.
Pulv. rhei.....¾ grain.
Ext. dulcamaræ.....1½ grains.
M. et ft. pil. No. j.
Sig.: One pill daily.—(*Journal of the American Medical Association.*)

### MIGRAINE.

Hirtz states that 4 grains each of caffeine and sodium benzoate often act very well, repeating the dose, if need be, every two hours until four doses have been taken. Graeme Hammond recommends 1½ grains each of methylene-blue and powdered nutmeg in capsule four times a day.

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### Irritating Cough of Phthisis.

When not accompanied by much expectoration, the following mixture is recommended —

℞ Codeinæ..... 4 grains.
Acidi hydrochlorici dil..... ½ drachm.
Spiritus chloroformi..... 1½ drachms.
Syrupi limonis..... 1 ounce.
Aquæ destil., q.s. ad..... 4 ounces.

M. et ft. emulsio.

Sig.: One teaspoonful at short intervals when cough is troublesome.—(*Murrell.*)

### Brittle Nails.

An ointment of 60 grains of oleate of tin to 1 ounce of ointment of rose-water is an elegant and efficient application to the finger-nails when brittle or marked with spots and ridges.

### Intestinal Fermentation with Constipation.

℞ Ext. aloes,
Pulveris rhei, of each..... 6 grains.
Benzosol..... 9 grains.
Ext. hyoscyami..... 6 grains.

M. et ft. caps. No. 12.

Sig.: One after meals.—(*Stuckey.*)

### Inflamed Rheumatic Joints.

Osler recommends:—

℞ Sodii carbonatis..... 6 drachms.
Tinct. opii..... 1 ounce.
Glycerini..... 2 ounces.
Aq..... 9 ounces.

M. Sig.: Saturate hot cloths with the lotion and apply to the parts.—(*Pennsylvania Medical Journal.*)

### Anæmia with Dysmenorrhœa.

Anæmia, with constipation and painful or difficult menstruation (dysmenorrhœa):—

℞ Ferratini..... 2 drachms
Rad. rhei pulv..... 4 drachms.
Sodii bicarb..... 2 drachms.
Ol. fœniculi..... 30 drops.

M. Sig.: Take a teaspoonful at night, in a wafer or dry in the mouth, and wash down with a draught of water.—(*Medical Fortnightly.*)

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# Jottings.

## NOSE BREATHING THE CITADEL TO PHYSICAL AND MENTAL HEALTH.

When an organ of the human body is not used as nature intended that it should be, it becomes useless and too often diseased. I believe that atrophied and hypertrophied conditions of the nasal passages are intensified because we use our mouths to breathe through instead of the nose. The long moist nasal passage intercepts dust, germs and various impurities. The air is fairly alive with floating dust and bacteria, as often seen in streaks of sunshine, and at the same time, the air is warmed and tempered for the lungs. But when the breathing is through the mouth, the dust is carried right into the delicate cells, and trouble ultimately follows. The unfortunates who inhale and exhale the breath through the mouth have but little lung power, and easily become victims of disease because they are not using the physical machinery given them for that purpose. By not breathing properly, the lower cells in the lungs are unaired and unswept year after year. Is it any wonder human beings so neglectful become anemic and consumptive. The lungs can be termed the engine of the body, and must be kept in good order; and this good order is only to be maintained by full, deep and regular inhalations through the nose. Few persons who use the nose appreciate the fact that they are less liable to various diseases than those who have allowed the nose to become closed. Few persons, too, understand how beneficial a simple breathing exercise is. Ten minutes of steady and deep breathing right down to the abdomen will, in many cases, cure nervousness and irritability. It sends newly vitalized blood to every part of the body. Consumptives can increase their chest measurements by daily exercises of this kind, and add years to their lives. Semi-invalids can paint roses in their cheeks by taking regular and systematic inhalations of fresh, pure air, but the breathing should be through the nose, and, if the nasal passages are closed because of disease, the growths therein must be removed and nature given a chance. Another thing that proper breathing will do, and that is to allay a cough. Nothing more irritates a cough than coughing, and much of it can be obviated by right breathing. When there is a tickling in the throat draw in a full breath through the

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nose, and hold it in until it reaches and warms and soothes every air cell. It is said that the nitrogen liberated and confined in the cells acts as a sedative to the irritated membranes, and in some manner controls the desire to cough. Whatever the philosophy is, there is no doubt that a person can help cure a cough by regular and full breathing to the extent of expanding the lungs, "expansion" without political significance, and holding the breath in until every cell gets its full share of new air. And in closing let me impress upon all the importance of full breathing and of keeping the nose open and using it as nature intended. The unused nose is as prone to abnormal and sometimes dangerous growths as the spark is to fly upward; therefore let us keep our noses open and clean.—O. W. ARCHIBALD, M.D., in *Northwestern Lancet*.

## LINSEED MEAL POULTICE.

Warm a basin, pour in *boiling* water; sprinkle in the meal, stirring vigorously, till it becomes of the consistency of thick porridge; spread on tow or old linen, turning in the edges all around; before applying put it against one's cheek to feel that it is not too hot. Retain in position with a broad flannel roller, secured with safety-pins. Renew every four hours or oftener. The poultice should not exceed half an inch in thickness. Caution is necessary in poulticing the chest of *infants* in order not to overload the chest and tire out the respiratory muscles.—Ashby & Wright, *Pediatrics*.

## CURING A BOIL.

A writer in the *Peoria Medical Journal* describes his method of treating boils. To render the procedure painless a few drops of cocaine are introduced into the tissue and cavity of the boil, using a very fine needle, which is at first allowed to rest with its point upon the inflamed surface with merely the weight of the syringe to gradually force it beneath the skin. If there is a drop of cocaine on the point of the needle it will soon prepare the way for the further and more forcible introduction without pain, and then the cavity is made the recipient of enough to completely anesthetize its surrounding tissue. When that is accomplished a little larger needle is readily introduced and several drops of ninety-five per cent. carbolic acid pressed tightly into the cavity. Absolute sterilization is invariably secured, and with absolutely no suffering to the patient whatever. A felon may be treated in the same way.

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## RESIDUAL URINE IN ENLARGED PROSTATE.

Residual urine in cases of enlarged prostate is due at first, according to A. G. Miller (*Scottish Med. and Surg. Jour.*) to neglect to empty the bladder. Accumulation is due to this becoming a habit.

The writer's advice is: After passing water in the usual way the patient should wait a minute or two and then try again. Practice this as frequently as possible, till only a very small quantity can be squeezed out (one drachm); when that point has been reached, twice or thrice daily. This acts in two ways: First, the small residuum of urine that may result from a careless act of micturition is got rid of. In the second place, the bladder tone is improved, and its function restored. It might be added that the habit of completely emptying the bladder is acquired. A still more important result is that the residual urine being diminished cannot possibly increase. *Obsta principiis* is a good working principle.

"I do not," says the writer, "bring this forward as a cure, or as a means of preventing residual urine from forming in every case of enlarged prostate. I merely suggest a safe and simple procedure which has apparently checked the increase of residual urine in several cases, and which may in some others at least postpone the almost inevitable catheter."

## IMPORTANT TIPS.

1. The value of small doses of tincture of aconite frequently repeated in the treatment of amygdalitis and in the initial stage of febrile diseases.

2. The value of painting the chest and back with liquor iodi fortis—diluted if necessary with an equal quantity of the tincture—in all cases attended with cough.

3. The value of a pill of exsiccated ferrous sulphate in conjunction with the administration of purgatives in the treatment of anemia.

4. The value of grain doses of gray powder with an equal quantity of Dover's powder from three to six times a day in the treatment of syphilis.

5. The value of large doses of the iodides in the treatment of tertiary syphilis.

6. The value of large doses of bromide of potassium in the treatment of the "heats and flushes" and other symptoms from which women suffer about the time of the menopause.

7. The value of large doses of quinine in the treatment

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of supraorbital neuralgia, and in the periodical febrile disturbances from which old malarial patients suffer.

8. The value of small doses of a saturated solution of camphor in alcohol in the treatment of autumnal or choleraic diarrhœa.

9. The value of small doses of perchloride of mercury in the treatment of infantile diarrhœa when the stools are green, slimy and offensive.

10. The value of sulphide of calcium in doses of a tenth of a grain in the treatment of boils, carbuncles and abcesses.

11. The value of nitro-glycerine and nitrite of amyl in the treatment of angina pectoric and allied conditions.

12. The value of alcohol in the treatment of fevers.

13. The value of flying blisters in typhoidal conditions. —William Murrell in *Medical Record.—St. Louis Med. and Surg. Jour.*

## Tired Feet.

The *Doctor's Magazine* recommends a hot foot-bath with an ounce of salt as very restful. Rapid relief from fatigue is also obtained by plunging the feet in ice-cold water, keeping them immersed until a sensation of warmth is experienced. Alcohol, in the form of spirit-baths, is a good tonic for the feet.

## Persistent Vomiting.

Mitchell has used cold water in the treatment of persistent vomiting with much success. He applies to the epigastrium towels wrung out of ice-water, which are changed every minute until the vomiting ceases. The treatment will be successful usually in fifteen or twenty minutes, and may then be discontinued, to be resumed if necessary. By these simple measures he has succeeded in stopping dangerous vomiting in a large number of instances—after childbirth, for example, when medicines and other external applications have failed to give relief. (*Virginia Medical Journal*, April 14, 1899.)

## Guaiacol Ointment.

Guaiacol applied locally seems to be a safe and efficient remedy in relieving the pain of arthritis deformans, acute articular or muscular rheumatism, sciatica, orchitis and epididymitis. One part of guaiacol to 10 or 15 parts of vaselin or lanolin should be applied to the painful parts. (*New England Medical Monthly.*)

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## Acute Bronchitis.

According to the *Indian Medical Record*, the most painful period in acute or subacute bronchitis is at the onset, when the expectoration is absent and the cough very severe. According to Dr. F. Edgeworth, of Bristol, caffeine, especially when associated with an alkali, facilitates the expulsion of the sputum and shortens the stage. He employs every three or four hours a dose of from 15 to 25 grains of citrate or acetate of potassium, and in addition at bed-time 5 grains of caffeine. Administered in this way he finds that caffeine quickly overcomes the spasm of the bronchial muscles, which checks the expulsion of the sputum and thus relieves the patient.

## Ichthyol in the Treatment of Fissure of the Anus.

Conitzer obtained most satisfactory results in the treatment of anal fissures with ichthyol. The fissure is first anæsthetized with cocaine, and pure ichthyol is applied with a bit of cotton on a glass rod. For subsequent applications, which are made every other day, anæsthesia is generally unnecessary. Cicatrization is usually very rapid, and stretching of the sphincter is not necessary. The bowels must be kept free. (*New York Medical Journal.*)

## Scarlatinal Desquamation.

Williams says that the process can be shortened by three or more days by means of regular inunctions all over the body (except the scalp) with a mixture of 1 part glycerin and 9 parts of 15-volume hydrogen peroxide acidulated with 1 per cent. of hydrochloric acid. (*Medical News.*)

## Incontinence of Urine.

According to the *Buffalo Medical Journal*, lycopodium has been used with success for this affection in children. Twenty drops of the tincture should be given three times a day, and this dose may be increased to 40 or 50 drops. It is, in some cases, more efficient than belladonna. (*New York Medical Journal.*)

## An Itching Ear.

Alexander D. Stirling writes to the Laryngoscope that itching of the auditory meatus is often due to irritation arising near the pharyngeal mouth of the Eustachian tube, and transferred to the ear. It follows that treatment, to have a permanently good effect, must be directed to the pharynx as well as the ear.

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THE
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# Editorial.

## UNNECESSARY DEATH.

It is a common saying that it is the unexpected which is constantly occurring. How often do we hear of the death of some one well known in the community whose death is a surprise—a surprise because of its suddenness, and the individual unknown to have and did not have that form of cardiac disease where sudden death was to be expected. We have for several years felt that some of these sudden or comparatively sudden deaths might be called unnecessary deaths. We call them unnecessary, because on the onset of the symptoms the proper treatment was not carried out. This was because medical men could not be had before the condition was practically beyond their power. To the public we must look for that early treatment which might possibly avert the fatal issue. Two cases in point occur to us at the moment. A few years ago a very prominent gentleman in Montreal was ill with pneumonia. In this disease, as is well known, the cardiac muscle is very apt to undergo fatty degeneration, and perhaps in it, more than any other, death from the much-abused term of heart failure is apt to occur. We all know how carefully and gradually we allow convalescents from pneumonia assume the erect position with a view of avoiding this

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occurrence. The gentleman referred to was doing exceedingly well, and a speedy convalescence was looked for. On the sixth or seventh night of his illness, finding the nurse asleep, he arose from his bed and walked a few paces to a table where his medicine was, and took it. The noise of his movements awoke the nurse, who at once assisted him towards his bed. Before reaching it he fainted, and in a few moments was dead. The second case which occurs to us was that of a fairly well-known gentleman, but who was generally known among his friends as being far from robust. He was taking his mid-day meal at a café when he was seen to sway backwards and forwards. Several rushed to his assistance, and he complained of being dizzy and weak. A dose of brandy was given and a carriage obtained, in which he was driven to his residence, nearly a mile distant. He reached it alive, but was in a semi-conscious condition, and never rallied, dying in a very short time. These are only a sample of not a few cases which have occurred in Montreal within the last twenty years. In these two cases there can be no question but that anemia of the brain was the condition present, and that the logical treatment was to have as speedily as possible placed the patients in the recumbent posture—nay—lowered the head and elevated the feet. Medical men know well how essential such early—in fact immediate—treatment is necessary in threatened death. Fortunately, in a somewhat extended practice in the administration of anesthetics, we have been spared the occurrence of a fatal issue. In one case, however, where apparently there was sudden paralysis of the heart, indicated by cessation of the pulse, and death was indeed imminent, complete inversion of the patient relieved that condition of the brain—anemia—which, it is admitted, is apt to occur in profound anesthesia. In such cases as we have referred to, if the positions we have named did not promptly give favourable results, we would not hesitate, and those promptly on the scene should not hesitate to invert the patient. Interest in cases of sudden death, due to the causes we have referred to, has, within a short time, been revived by a paper from Dr. Paulesco, of the Physiological Laboratory of Sarbonne, which appears in a late number of the *Journal de*

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*Medicine Interne.* By experimental research he proves that sudden death is very apt to occur where a condition of anemia of the brain is intensified by the brusque assumption of the erect posture. Dr. Paulesco points out as an interesting fact that the respiratory activity which in these cases is the first to come to a standstill is, under certain conditions, temporarily intensified by the cerebral anemia consequent on assuming the upright posture. The logical deduction from these remarks is that the public should know that, under any condition where faintness is a prominent symptom, death is imminent if the patient is kept in the erect or semi-erect position, and that, till medical assistance arrives, it is the best practice to place the person on the back. Were this generally known, we believe we would have fewer cases of what we think we not misaptly have called "Unnecessary Death."

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## PERSONAL.

Dr. S. E. Tabb, of Sherbrooke, died on the 6th of November after an illness of about six months. He was a graduate of McGill University, and for a short time practiced in Montreal, subsequently removing to Sherbrooke. On the formation of the Medical Faculty of Bishop's College he accepted the chair of Botany, which he filled till he left the city.

Dr. Frederick A. Hopkins, of Montreal, was killed at St. Henri, near Montreal, on the 1st of December by being struck by an express train. So far as can be gathered from a medical friend who was with him, he boarded a local train for Montreal, when his friend lost sight of him. He had originally intended returning to the city by an electric car, and, it is believed, seeing one approaching, he jumped from the car on which he was, landing just in front of a passing train, the engine of which struck him, killing him instantly. He graduated from McGill University in 1892, and began practice at Cookshire, where his family resided. About four years ago he removed to Montreal and began practice, and we believe was rapidly surrounding himself with a large circle of patients. He was an Assistant Surgeon to the Samaritan Free Hospital for Women. He was of a somewhat retiring disposition, but among those who knew him well he was highly thought of, and, if his life had been spared, we have no doubt he would have made his mark among his professional brethren. He was married about two years ago, and leaves a wife and one child.

Surgeon-Major C. W. Wilson, of Montreal, who went to South Africa as one of the medical officers of the 2nd (service) Bat-

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talion of the Royal Canadian Regiment, returned with that portion which sailed direct from Capetown to Halifax. He is looking peculiarly "fit," as indeed has every one who has returned from South Africa.

Dr. Wolfred Nelson (C.M., M.D., of Bishop's and McGill, 1873) was in Montreal on the 8th of November to attend the Annual Dinner of the students and graduates of Bishop's College Medical Faculty. He returned to New York next day.

Dr. Marshall, of Huntingdon (M.D., of Bishop's, 1879), and Dr. de Mouilpied, of Hemmingford (M.D., Bishop's, 1881), came to Montreal to attend the Annual Dinner of students and graduates of Bishop's Faculty of Medicine on the 8th of November, held at the Place Viger hotel.

Dr. R. E. Leprohon (M.D., Bishop's, 1879), is practicing at St. Henri, one of the suburbs of Montreal.

Dr. Edmond Robillard, one of the best-known physicians of Montreal some seventeen years ago, and who since that time has resided in France and at Monte Carlo, has returned to this city with the intention of permanently residing here. He finds many of his friends have passed to the great majority, but those who remain extend to him a hearty welcome.

The issue of the present number has been delayed by the serious illness of the Editor, who was confined to bed from the 6th December to the 17th December. We are glad to say that he is now perfectly convalescent, and the first day of the new century, it is believed, will find him quite fit for work.

Dr. Lacombe, one of the Demonstrators of Anatomy in the Medical Faculty of Bishop's College, has been re-elected by a large majority to represent one of the divisions of Montreal city in the Quebec Legislature.

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# Book Reviews.

**A Manual of Syphilis and the Venereal Diseases,** by James Nevins Hyde, A.M., M.D., and Frank Hugh Montgomery, M.D. Second Edition, revised and enlarged. Publishers, W. B. Saunders & Co., Philadelphia. Canadian Agents: J. A. Carveth & Co. Toronto, Ont. Price, $4.00 net.

This work is beautifully prepared, the paper, printing and colored plates being rather better than the average. The text is very well written, the style clear and elegant. A great deal of thought is apparent in a careful consideration of the many-sided social questions in connection with these diseases, and forms part of the introductory chapter. Syphilis is carefully considered, and it is interesting to note the axiom appearing in the first paragraph on the treatment of Syphilis, viz.: "The worst errors committed in the

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management of Syphilis are due to trusting exclusively to the efficacy of drugs for the relief of the disease." This points to hygienic care and proper diet as the great keys to successful treatment in syphilis as in other diseases. A discussion of the use and abuse of mercury contains valuable information; the authors wisely advocate a rational treatment, and not allowing conventional rules to restrict the adaptation of remedy to each patient. The consideration of gonorrhœa and its sequelæ is excellent. The entire work is a credit to those who have assisted in its production.

G. F.

**Modern Surgery, General and Operative,** by John Chalmers DaCosta, M.D. Third Edition, revised and enlarged. Publishers, W. B. Saunders & Co. Canadian agents: J. A. Carveth & Co., Toronto. Price, cloth, $5.00; half morocco, $6.00.

It is only two years ago that the second edition of this popular work was placed before us. In this third edition much material has been added, increasing the volume by more than two hundred pages, and containing over one hundred new illustrations. It would appear, however, that the original plan of the work remains unchanged, as the branches of Opthalmology, Gynecology, Rhinology, Otology and Laryngology have not been considered. Throughout the text can be seen the insertion of valuable matter, which amplifies the former terse consideration. In considering the tertiary treatment of Syphilis it is interesting to note the explanation of the action of Iodides as given by Cyon that "small doses combine with some products of the thyroid gland and form toxic iodothyrin. Large doses are diuretic from soluable salts, and are rapidly eliminated." Many practical therapeutists pin their faith to large doses of the Iodides, and with good reason too, and yet have not accounted for their action in such a simple manner. As a whole, this work is probably the most satisfactory published short of the elaborate works of two or more volumes. We recommend it with great pleasure, not only to the student, but to the busy practitioner.

G. F.

**A Text-Book of the Diseases of Women.** By Henry I. Garriguer, A.M., M.D, Gyneocologist to St. Mark's Hospital, in New York City, Gynecologist to the German Dispensary in the City of New York, Consulting Obstetric Surgeon to the New York Maternity Hospital, Consulting Physician to the New York Mother's Home and Maternity Hospital, ex-President of the German Medical Society of the City of New York, Fellow of the American Gynecological Society, Fellow of New York Academy of Medicine, Member of Society for Medical Progress, of Eastern Medical Society, of New York County Medical Society, etc., with 367 illustrations. 3rd edition, thoroughly revised. Philadelphia, W. B. Saunders & Co., 1900. Canadian agents: J. A. Carveth & Co., Toronto, Ontario. Price, cloth, $4.50 net. Sheep or half morocco, $5.50.

For the third edition the author has carefully and thoroughly revised the whole work. What seemed antiquated or of minor im-

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portance has been left out, while considerable and new material has been admitted bringing the work up to date. Many new illustrations have been added. The index has been improved and increased, thus facilitating research in a work containing information upon so many different subjects. The first and second editions of this work received most favorable comment by the reviewers connected with the leading medical journals on both sides of the Atlantic. The *Medical Record*, of New York, said: "It has by the sheer force of its intrinsic merit shouldered its way through a crowd of more ambitious works up to the front rank," while the *American Journal of the Medical Sciences* said: "It is one of the most complete treatises on Gynecology which we have."

After a careful perusal of this third edition, and judging from a reference to several chapters on subjects in which we are especially interested, we can safely say it is one of the best text-books for students and practitioners which has been published in the English language; it is condensed, clear and comprehensive. The profound learning and great clinical experience of the distinguished author find expression in this book in a most attractive and instructive form. Any practitioners to whom experienced consultants may not be available will find in this book invaluable counsel and help, and, although in the cities difficult and dangerous gynecological cases should have the benefit of the specialist's advice, yet in the country, where the latter cannot be had, the family physician, by the aid of such a book as this, will be able to safely guide his patient back to health.

Two chapters in particular will be welcomed, although they are innovations, namely, on Hemorrhage and Leucorrhœa. As the author says they are not diseases but symptoms, but they play so great a part in the diseases of women, and so often require symptomatic treatment, that he considers it to be in the interest of the general practitioner to treat them separately.

We were pleased to notice in this connection that he lays more stress on the constitutional than on the local treatment, especially in young girls, on whom he says it is seldom necessary to apply anything locally. Among the drugs he speaks highly of the value of hydrastis, aletris and cimicifuga internally.

A. L. S.

**A Book of Detachable Diet Lists** for Albuminuria, Anæmia and Debility, Constipation, Diabetes, Diarrhœa, Dyspepsia, Fevers, Gout or Uric Acid Diathesis, Obesity, Tuberculosis and a Sick-room Dietary, compiled by Jerome B. Thomas, jun., A.B., M.D.; Instructor in Materia Medica, Long Island College; Assistant Bacteriologist to Hoagland Laboratory. Second edition, revised. Published by W. B. Saunders, 925 Walnut Street, Philadelphia, 1900. Canadian Agents: J. A. Carveth & Co., Toronto. Price, $1.25 nett.

This is a very valuable collection of diet lists and sick-room dietary, and is offered to the profession as a practical aid to the better practice of therapeutics. The busy practitioner has seldom the time to write out systems of diet for his patients, and yet to do so is of the greatest importance.

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It is an acknowledged fact that a great deal of the success which the late Sir Andrew Clark met with was due to the care and preciseness with which he wrote out a diet for his patients. If that well-known physician were alive to-day, he would find this book of inestimable value to him, and indeed it ought to be to every practicing physician. In a portable form there is offered him a set of ten lists (compiled from standard works on dietetics), including the pathological conditions, in the treatment of which diet plays so important a part. Physicians who, after enumerating milk, beef tea, milk toast and gruel, find their mental list of bland foods rapidly growing hazy, will find the sick room dietary of practical benefit, when we have to humor the appetite, as, for example, a typhoid patient who rejects milk. An Appendix gives a brief description of the technique of rectal alimentation, and of the special preparation of foods for such use. The lists are numbered and the key to the numbers is reserved for the physician. The work is one of those practical treatises which must be seen and examined to appreciate its value.

F.W.C.

**Saunders' Pocket Formula**, with an Appendix containing Posological table; Formula and doses for Hypodermic Medication; Poisons and their Antidotes; Diameters of the Female Pelvis and Fœtal Head; Obstetrical Table; Diet List for various Diseases; Material and Drugs used in Antiseptic Surgery; Treatment of Asphyxia from Drowning; Table of Incompatibles; Eruptive Fevers; Weights and Measures. By William Powell, M.D., author of "Essentials of Diseases of Children." Sixth edition thoroughly revised. Philadelphia, W. B. Saunders & Co., 1900. Canadian Agents: J. A. Carveth & Co., Toronto. Price, $2.00.

The title of this book, as given above, is its contents boiled down, and shows that it contains a mass of very valuable information. Among practitioners in the country there is a continual outcry for formula. The result is that most of the leading medical periodicals, in each issue, now publish prescriptions recommended by well-known medical men, and some also who are not generally known. This is a valuable contribution, so far as it goes, but to be of ever-ready value they must be cut out and arranged alphabetically as to diseases, or they cannot be readily referred to. In fact, this is what is done in this book, and prescriptions recommended in all the principal diseases can be found instantly. In this lies its value, and upon the whole the formula are good. Blank leaves are inserted, on which can be entered formula, which the medcal man has himself found useful.

F. W. C.

**The Physician's Visiting List** (Lindsay & Blakiston) for 1901. Philadelphia, P. Blakiston's, Son & Co., 1012 Walnut Street.

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SPECIFIC EFFECTS AND INSTRUCTIONS FOR USE.

TO STIMULATE THE APPETITE.—Take half the Tonic Dose, as directed, in very cold (not iced) water, fifteen minutes before eating.

TO STIMULATE DIGESTION AND ASSIMILATION.—Take the remaining half of the Tonic Dose, during meal-time, in water.

TO INCREASE RAPIDLY IN WEIGHT.—Take the Tonic Dose, as directed, and adopt the free use of new milk in addition to the regular food.

TO SUSTAIN MENTAL EXERTION.—Mix two teaspoonfuls in a tumblerful of cold water, and drink small quantities occasionally during the hours of intellectual work.

TO GIVE POWER TO THE VOCAL CHORDS.—Take the Tonic Dose fifteen minutes before singing or lecturing.

Where *mucous expectoration* is difficult, the Tonic Dose repeated every two hours will effect its removal with very little effort.

TO PREVENT RECURRENCE OF NIGHT SWEATS.—Take the Tonic Dose at each meal and at bed-time. The contractile power is imparted to the nerves, which are connected with the sweat glands.

TO PREVENT SWEATING HANDS AND FEET.—Take the Tonic Dose as directed, avoid undue excitement, and occupy the mind with pleasant unwearying pursuits.

FOR CONVALESCENCE from Typhoid and other low Fevers, and Debility from residence in hot or malarial localities, employ the Tonic Dose.

TO STRENGTHEN AND DEVELOP NURSING INFANTS.—Let the mother take the Tonic Dose as directed with the food.

TO PROMOTE SLEEP.—Take the Tonic Dose before eating. This applies particularly to sufferers from shortness of breath.

## NOTICE CAUTION.

The success of Fellows' Syrup of Hypophosphites has tempted certain persons to offer imitations of it for sale. Mr. Fellows, who has examined samples of several of these, FINDS THAT NO TWO OF THEM ARE IDENTICAL, and that all of them differ from the original in composition, in freedom from acid reaction, in susceptibility to the effects of oxygen, when exposed to light or heat, IN THE PROPERTY OF RETAINING THE STRYCHNINE IN SOLUTION, and in the medicinal effects.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing, to write "Syr. Hypophos FELLOWS."

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles: the distinguishing marks which the bottles (and the wrappers surrounding them) year can then be examined, and the genuineness—or otherwise—of the contents thereby proved.

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